APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

____ The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

__T__ The waiver will be operated by Bureau of Community Supports and Services , a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2. NOTE: For individual's served through this waiver who choose available consumer directed/self directed services, the following definitions of services are the same for either a traditional delivery system or consumer directed/self directed services.

a. __ Case Management

___ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1.____Yes 2.___No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1.____Yes 2.___No

___ Other Service Definition (Specify):

b.___ Homemaker:

___ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

___ Other Service Definition (Specify):

c.___ Home Health Aide services:

___ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this

waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

___ Other Service Definition (Specify):

d.___ Personal care services:

___ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. when specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

___ Payment will not be made for personal care services furnished by a member of the individual's family.

___ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.
Justification attached. (Check one):

___ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

___ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

___ A registered nurse, licensed to practice nursing in the State.

___ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

___ Case managers

___ Other (Specify):

3. Frequency or intensity of supervision (Check one):

___ As indicated in the plan of care and regulations.

___ Other (Specify):

4. Relationship to State plan services (Check one):

___ Personal care services are not provided under the approved State plan.

___ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

___ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

___ Other service definition (Specify):

e. ___ Respite care:

___ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

___ Other service definition (Specify):

Supports and services provided for relief of those persons normally providing care to individuals unable to care for themselves furnished on a short term basis, by a licensed respite facility. These services are necessary to keep individuals from being institutionalized. Individual and family support services cannot be provided while an individual is in a center based respite care setting.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

__ Individual's home or place of residence
___ Foster home
___ Medicaid certified Hospital
___ Medicaid certified NF
__ Medicaid certified ICF/MR
___ Group home

T A Licensed respite care facility, with the availability of community outings, Community outings would included on the approved CPOC and would include activities such as school attendance, or other school activities, or other activities the individual would receive if they were not in the center-based respite facility. This community outings would allow the individual's routine not to be interrupted.

___ Other community care residential facility approved by the State that its not a private residence (Specify type):

___ Other service definition (Specify):

f. ___ Adult day health:

___ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per

day).Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1.___Yes 2.___No

___ Other service definition (Specify):

g.____ Habilitation:

____ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

____ Residential habilitation/supervised independent living: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

____ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 1 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.
Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

___ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

___ Individuals will not be compensated for prevocational services.

___ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

__ Educational services, which consist of special education and related services as defined in section s (15) and (17) of the individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Supported employment services, ~~which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly~~

~~work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.~~

are services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602 (16)and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16and 71). Supported employment is competitive work in an integrated work setting, or employment in an integrated work setting in which the individuals are working toward competitive work, consistent with strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of individuals with ongoing support services for whom competitive employment has not traditionally occurred. These are services provided to individuals who are not served by Louisiana Rehabilitation Services and need more intense, long term follow along and usually cannot be competitively employed because supports cannot be successfully faded.

Supported employment models are:

1. Individual placement model**:** A supported employment placement strategy in which an employment specialist (job coach) places a person into competitive employment, provides training and support, and then gradually reduces time and assistance at the worksite.

2. Enclave: An employment situation in competitive employment in which a group of eight or fewer workers with disabilities are working at a particular work setting. The disabled workers may be disbursed throughout the company and among non-disabled workers or congregated as a group in one part of the business.

3. Mobile Work Crew: A group of eight or fewer workers with disabilities who perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor)

~~Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:~~

~~1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and~~

~~2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.~~

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

☐ Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services, except for residential habilitation where rate paid provider excludes transportation costs.

1. ☐ Yes 2. ☐ No

☐ Other service definition (Specify):

Employment Related Training are services not Available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602 (16)and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16and 71). Services are aimed at providing individuals opportunities for employment and related training in work environments in accordance with U.S. Dept. of Labor regulations and guidelines. Employment related training services include related training designed to improve and/or maintain the individual's capacity to perform productive work, and function adaptively in the work environment. Service are provided one or more hours per day, for one or more days per week. Examples of employment related training include: An individual receives assistance and prompting in the development of employment related skills. This may include assistance with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, and behavioral support needs and any medical task which can be delegated. An individual is employed at a commensurate wage at a provider facility for a set or variable number of hours. An individual observes an employee of an area business to obtain information to make an informed choice regarding vocational interest. An individual is taught how to use a vacuum cleaner. An individual learns how to make choices and order from a menu at a fast food restaurant. An individual is taught how to observe basic personal safety skills. An individual is assisted in planning appropriate meals for lunch while at work. An individual learns basic personal finance skills. An individual and, as appropriate, his/her family receive information and counseling on benefits planning and assistance in the process.

h. ☐ Environmental accessibility adaptations:

T Those physical adaptations to the home or vehicle, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the

installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, exterior fencing, general home repair and maintenance etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes. A cap of $4,000 for a 3 year period for this service will be per individual. On a case by case basis, with supporting documentation and based on need, an individual may be able to exceed this cap with the approval of BCSS and with the limits beyond the capped prior authorized.

_____Other service definition (Specify):

i.__ Skilled nursing:

___ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

T Other service definition (Specify): Services provided by a licensed nurse, either an RN or LPN, to individuals who need skilled nursing services :

A. Services would include diabetes maintenance, oxygen therapy, ventilator tracheotomy care; hydration, nutrition, and/or medication via a gastronomy; severe musculoskeletal conditions/non-ambulatory status that require increased monitoring; dialysis; treatment for cancer requiring radiation/chemotherapy and end of life care not covered by hospice services.
B. Services may also include those relating to the use of life sustaining equipment necessary to sustain, monitor, treat an individual to ensure sufficient body function. Such medical equipment may include: ventilator; suction machine; pulse oximeters; apnea monitor; nebulizers.

AND

Skilled nursing services must have a physician's order, letter of medical necessity, an individual nursing service plan, and be included in the recipient's CPOC. All state plan services must be utilized before accessing this service.

j.___Transportation:

____ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This

service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation s vices under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

___ Other service definition (Specify):

k.□ Specialized Medical Equipment and Supplies:

□ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with he environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. A cap of $4,000 for a 3 year period for this service will be per individual. On a case by case basis, with supporting documentation and based on need, an individual may be able to exceed this cap with the approval of BCSS and with the limits beyond the capped prior authorized.

__ Other service definition (Specify):

l.___ Chore services:

___ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, care giver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

___ Other service definition (Specify):

m.□ Personal Emergency Response Systems (PERS)

□ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2.

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular care giver for extended periods of time, and who would otherwise require extensive routine supervision, or where older care givers are involved or other communication systems are not adequate to summon emergency assistance.

___ Other service definition (Specify):

n.___ Adult companion services:

___ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

___ Other service definition (Specify):

o.___ Private duty nursing:

___ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

___ Other service definition (Specify):

p.___ Family training:

__ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

___ Other service definition (Specify):

q.___ Attendant care services:

___ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

___ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

___ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

___ Other supervisory arrangements (Specify):

___ Other service definition (Specify):_____

r. ___ Adult Residential Care (Check all that apply):

___ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed three. Separate payment will not be made for Individual & Family Support Services, homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services. Adult foster care in Louisiana is licensed as Substitute Family Care.

___ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

___ Home health care
___ Physical therapy
___ Occupational therapy
___ Speech therapy
___ Medication administration
___ Intermittent skilled nursing services
___ Transportation specified in the plan of care
___ Periodic nursing evaluations
___ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

___ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s.___ Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

1. Individualized and Family Support - is direct support and assistance for an individual or for the relief of the care giver, provided in or out of the individual's home, to achieve

and/or maintain the outcomes of increased independence, productivity, and inclusion in the community as outlined in the person's comprehensive plan of care and to enhance family functioning.

For individuals having significant disabilities and who do not have sufficient natural supports, the Individual and Family Support staff can provide services as follows:

a. Provide orientation and information to acute hospital nursing staff re: the recipients specific ADL, communication, positioning and behavioral needs. Decision regarding medical care will not be made by the Individual and Family support worker, but will be made by either the individual or the individual's legal representative.

b. Provide direct services related to the individual's disability during waking hours when natural supports are unavailable in order to provide the individual with continuity of services. Direct services would be those services that would assist the individual with their daily living skills, or positioning, or training and will not be medical procedures.

Individual and Family Supports services will not be provided in licensed respite care facility and the provider may not bill for individual and family support services for the same time on the same day as respite services.

Individual and family supports may consist of shared supports which allows the availability of where up to three people may live together in a variety of settings and share individual and family supports service staff. The shared staff would be reflected on the CPOC and based on an individual by individual determination and rates would be adjusted accordingly.

Night companion of individual and family supports is the availability of direct support and assistance provided while the individual with disabilities is sleeping. The direct support professional is not required to be awake at all times, but must be immediately available and alert as needed and requested.

Individual and Family Support providers may be members of individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Family members who provide and Individual and Family Support services must meet the same standards as providers who are unrelated to the individual.

Supervision of Individual and Family Support services may be furnished by the licensed agency providing Individual and Family Support services, the licensed agency providing SIL services or case managers or individual or individual's authorized representative(s).

2. Community Integration Development - is the development of opportunities to assist individuals in becoming involved in their community with the creation of natural supports. Community Integration Development would be available to individuals already residing in

the community and those individuals who would transition from and ICF/MR. The purpose is to encourage and foster the development of meaningful relationships in the community reflecting the persons choices and values. For example: doing preliminary work toward membership in civic, neighborhood, church, leisure, etc. groups. This service differs from day habilitation in that it is building community relationships and not focused on vocational based training.

To bill for Community Integration Development, the individual must be present. It will be person centered plan driven and there will be a cap of 60 hours per individual in 12 consecutive months. Community Integration and Development cannot be billed at the same time as day habilitation.

3. Professional Services - are direct services to the individual to be used only when the services are not covered under the state Medicaid plan and/or public school programs. The purpose of these services is to increase the individual's independence, participation and productivity in their home, work and community. Service intensity, frequency, and duration will be determined by the individual's need. Professionals must be licensed in the specific area in which service(s) being offered. Professional services will include the following: social worker, psychologist, and nursing services. There is a $1,500 per individual per plan of care year capped for professional services. If the individual reaches the cap before the expiration of the plan of care year and the individual's health and welfare are at risk, on a case by case basis and based on additional documented need for services, additional services can be prior authorized for approval.

4. Professional Consultation - are services to the individual which may be direct or indirect and are to be used only when the services are not covered under the state Medicaid plan and/or public school programs. Consultative services and training will be provided for specific individuals and not for general training on MR/DD Waiver services. Indirect services would include assessments and non-direct intervention modalities. The purpose of these services is to train natural and formal supporters to implement training or therapy, which will increase the individual' independence, participation and productivity in their home, work and community. These services are not meant to be long-term services, but instead are normally meant to provide short-term or intermittent training or therapy to develop critical skills which may be self-managed by the consumer or maintained by individual need. These services may include assessments and periodic reassessments. Individuals must be licensed in the specific area in which training or consultation is being offered. Professional services will include the following: psychologist, social worker, and R.N. There is a cap of $750 per individual per plan of care year for professional consultation. If the individual reaches the cap before the expiration of the plan of care year and the individual's health and welfare are at risk, on a case by case basis and based on additional documented need for services, additional services can be prior authorized for approval.

5. Transition Start Up Expenses - are one-time, set-up expenses for individuals who make the transition from an ICF/MR to their own home or apartment in the community. This one time life time maximum service of $3,000 per individual, is for security deposits that are required to obtain a lease on an apartment or home and set up fees or deposits for utilities (telephone, electricity, heating by gas) and essential furnishings to establish basic living arrangements

which are bed, chair, a dining table and chairs, eating utensils, and food preparation items and a telephone.

6. Transitional Professional Support Services- is a system of using specialized staff and resources to intervene in and stabilize a crisis situation caused by any severe behavioral or medical circumstance that could result in loss of a current community-based living arrangement. These transitional professional supports and services would be a safety net for an individual that has transitioned from an ICF/MR and may include such supports, beyond the cap of the professional services and professional consultation, as additional psychological consultation or therapy, nursing or social work services.

t.____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

___ Physician services
___ Home health care services
_____ Physical therapy services
_____Occupational therapy services
____ Speech, hearing and language services
___ Prescribed drugs
___ Other State plan services (Specify):

u.___ Services for individuals with chronic mental illness, consisting of (Check one):

___ Day treatment or other partial hospitalization services (Check one):

___ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
b. occupational therapy, requiring the skills of a qualified occupational therapist,
c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
d. drugs and biologicals furnished for therapeutic purposes,
e. individual activity therapies that are not primarily recreational or diversionary,
f. family counseling (the primary purpose of which is treatment of the individual's condition),
g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care nd treatment), and
h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

___ Other service definition (Specify):

___ Psychosocial rehabilitation services (Check one):

___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
b. social skills training in appropriate use of community services;
c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,
b. prevocational services,
c. supported employment services, and
d. room and board.

___ Other service definition (Specify):

___ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

___ This service is furnished only on the premises of a clinic.

___ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERT	OTHER STANDARD
Individualized and Family Support	Individual or organization licensed as Supervised Independent Living, Personal Care Attendant	LRS 28: 380-451; LRS 28: 380-451	N/A	DHH/BCSS Standards for Pa
Community Integration Development	Individual or organization licensed as Supervised Independent Living or Personal Care Attendant.	LRS 28: 380-451; LRS 46:1971-1980	N/A	DHH/BCSS Standards for Pa
Professional Services	Individuals or agencies licensed to provide psychological, nursing, social work, and furnished through a home health agency.	LAC 48: 7701-7785 nurse LRS 37:2701-2723 social work LRS 37:2353 psychologist	N/A	DHH/BCSS Standards for Pa
Professional Consultation	Individuals or agencies licensed to provide psychological, nursing, social work, and furnished through a home health agency.	LAC 48: 7701-7785 nurse LRS 37:2701-2723 social work LRS 37:2353 psychologist	N/A	DHH/BCSS Standards for Pa
Transitional Professional Support Services	Individual or organization licensed to fulfill their role on the approved specialized staff and resources to intervene in and stabilize a situation caused by any sever behavioral or medical circumstance that could result in loss of a current community-based living arrangement.	LAC 48: 7701-7785 nurse LRS 37:2701-2723 social work LRS 37:2353 psychologist	N/A	DHH/BCSS Standards for Pa
Personal Emergency	Agency enrolled in Medicaid to provide personal emergency response system. The provider shall	N/A	N/A	DHH/BCSS Standards for Pa

Response System	install and support PERS equipment in compliance with all applicable federal, state, county and local laws and regulations and meet manufacturer's specifications, response requirements, maintenance records, and enrollee education.			
Environmental Accessibility Adaptation	Individual/agency deemed capable by recipient's family and provider. When required by state law, the person performing the service must meet applicable requirements for professional licensure. When building code standards are applicable, modifications to the home shall meet such standards.	When applicable	N/A	Local (City or Parish) occupa license DHH/BCSS Standards for Pa
Specialized Equipment and Supplies	Vendors of technological equipment and devices	N/A	N/A	All items shall meet applicabl standards of manufacture, des and installation
Substitute Family Care (Adult Foster Care)	Licensed as a Substitute Family Care Agency	LRS 46: 1971-1980	N/A	DHH/BCSS Standards for Pa

SERVICE	PROVIDER	LICENSE	CERT.	OTHER STANDARD
Center-Based Respite	Licensed Center-Based Respite Care service provider	LRS 46: 1401-1424	N/A	DHH/BCSS Standards for Pa
Supported Employment	Licensed Adult day care provider	LAC, Title 48, Chapter 43: 4301-4329	N/A	DHH/BCSS Standards for Payment
Day Habilitation	Day Habilitation	LAC, Title 48, Chapter 43: 4301-4329	LAC, Title 48, Chapter 43: 4301-4329	N/A
Employment Related Training	Licensed Adult day care provider	LAC, Title 48, Chapter 43: 4301-4329	N/A	DHH/BCSS Standards fo Payment
Skilled Nursing Services	RN or LPN through licensed agencies enrolled in Medicaid	La. State Board of Nursing and La. State Board of Practical Nursing	N/A	DHH/BCSS Standards for Pa Complete Medicaid provider Enrollment agreement, PE-50
Residential Habilitation/Supervised Independent Living	SIL	LRS AGENCY 28: 380-451	N/A	DHH/BCSS Standards for Pa Complete Medicaid provider Enrollment agreement, PE-50
One-time Transitional Services	Office for Citizens with Developmental Disabilities (OCDD)	LRS 28:380,	N/A	DHH/BCSS Standards for Pa Complete Medicaid provider Enrollment agreement, PE-50

Attachment II
Outcomes for Provider Standards
Department of Health and Hospitals
Home and Community-Based Waiver Provider Standards

The outcomes outlined below are a summary of expectations for Home and Community-Based (HCB) Waiver service providers.

I. New providers must meet minimum expectations prior to providing HCB Waiver Services.

II. Enrolled service providers must meet ongoing expectations.

III. Service providers must work with recipients and case managers during transfers or discharges from their services.

IV. Service providers shall adhere to BCSS and State policies regarding Abuse, Neglect and Critical Incidents including immediate jeopardy situations.

V. Service providers will insure that direct support staff meet minimum expectations for training prior to working with recipients.

VI. Service providers will provide competency-based, results driven training on an annual basis for all employees.

VII. Administrators and/or Program Directors must meet minimum standards of education and experience.

VIII. Direct Support staff must meet legal and quality expectations.

IX. Support Provider agencies must maintain strategies for staffing back-up and emergency situations.

X. Service Providers must maintain current quality assurance / quality enhancement plans consistent with personal outcomes.

XI. Service providers must work collaboratively with case managers/recipients during program planning activities.

XII. Service Providers must maintain a current service plan consistent with their assigned roles in the comprehensive plan of care.

XIII. Service Providers will maintain and implement polices that insure recipient's rights and due process.

SECTION 1915(c) WAIVER FORMAT

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1.____ Low income families with children as described in section 1931 of the Social Security Act.

2. T SSI recipients (SSI Criteria States and 1634 States).

3.____ Aged, blind or disabled in 209(b) States who are eligible under ə 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4.____ Optional State supplement recipients

5.____ Optional categorically needy aged and disabled who have income at (Check one):

a.____ 100% of the Federal poverty level (FPL)

b.____% Percent of FPL which is lower than 100%.

6. T The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

T A. Yes _____ B. No

Check one:

a.____ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. T Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) T A special income level equal to:

T 300% of the SSI Federal benefit (FBR)

___% of FBR, which is lower than 300% (42 CFR 435.236)

$____ which is lower than 300%

(2)___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5)___ Aged and disabled who have income at:

a.____ 100% of the FPL

b.___% which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8.____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under ə435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (ə435.217). For individuals whose eligibility is not determined under the spousal rules (ə1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR ə435.726 and ə435.735 just as it does for other individuals found eligible under ə435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under ə1924.

REGULAR POST-ELIGIBILITY RULES--ə435.726 and ə435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is

protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--ə1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of ə1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The ə1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in ə1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the ə1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual=s maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. T **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. ə **435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. T The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3) T The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level):___%

(5)___ Other (specify):
_____

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one): *N/A*

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.

F.___ The amount is determined using the following formula:

G.__) T__ Not applicable (N/A)

3. Family (check one) *N/A*:

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State=s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:
$____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of standard.

E.___ The amount is determined using the following formula:

F.___ Other

G._) T___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)___**209(b) State, a State that is using more restrictive eligibility requirements than SSI**. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percentage of the Federal poverty level:____%

(5)___ Other (specify):

B.___ The following dollar amount: $____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under ∋435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121:

B.___ The medically needy income standard_____;

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above:_____% of

E.___ The following formula is used to determine the amount:

F.___ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State=s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:

$_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.

E.___ The following formula is used to determine the amount:

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2.____ The State uses the post-eligibility rules of ə1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under ə1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level: ___%

(e)___ The following dollar amount $___**

**If this amount changes, this item will be revised.

(f)___ The following formula is used to determine the needs allowance:

(g)___ Other (specify):

If this amount is different from the amount used for the individual=s maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual=s maintenance needs in the community.

STATE: Louisiana DATE: April 1, 2003
:

APPENDIX D
ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

___ Discharge planning team

_T_ Physician (M.D. or D.O.)

_T_ Registered Nurse, licensed in the State

_T_ Licensed Social Worker

_T_ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_T_ Other (Specify):
Medical Certification Specialist is a position which may be filled by persons with training and experience in nursing, pharmacy, dietetics/nutrition or medical technology.
Health Standards Certification Specialist is a position which may be filled by persons with training and experience in social and Medicaid services.

Individuals listed above may perform initial evaluations, may work together when necessary and may also work independently based on the determination made at the BCSS regional office level as determined through the Comprehensive Plan of Care Planning process.

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

___ Every 3 months

___ Every 6 months

__T__ Every 12 months

_____Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

__T__ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

___ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

___ "Tickler" file

_T_ Edits in computer system

_T_ Component part of case management

___ Other (Specify):

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

___ By the Medicaid agency in its central office

___ By the Medicaid agency in district/local offices

__T__ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

__T__ By the case managers

___ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

___ By service providers

___ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

T The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

___ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
      Yes, Form 18-W and 90-L
   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
      Yes, labeled as Attachment to Appendix D-4, 3.b. and c.
   c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
      Yes, labeled as Attachment to Appendix D-4, 3.b. and c.
   d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.
      Yes, labeled as Attachment to Appendix D, Offering of Fair Hearing.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Copies are maintained in the case management agency=s offices and in the Bureau of Community Supports and Services Regional offices.

Attachment II
Appendix D -4. 3. b. and c.

Description of State's Procedures for Informing Eligible Individuals or their Legal Representatives of the Alternatives Available Under the Waiver and Allowing Choice Of Institutional /Community Services

There is a single form for all institutional/waiver choices. The state includes choice of institutional/community services form (LTC/CS) in the packet of forms used by application centers and state eligibility staff who take applications for Nursing Facility, ICF/MR, or HCBS waiver services. Information about alternatives is provided and the form is required to be completed for every application using that packet. Individuals offered MR/DD Waiver services, will complete the LTC/CS to indicate whether they will participate in the MR/DD Waiver or chose institutional services. Additionally, the 90-L for is completed by the physician to state the level of care required by the recipient and the families also chooses between facility based care or waiver services. A copy of the LTC/CS and the 90-L is found in Attachments to Appendix D.

ATTACHMENT II TO APPENDIX D-4, 3.a.

BHSF Form 18-W
Issued 05/02 IV

DEPARTMENT OF HEALTH & HOSPITALS
Medicaid Program
Adequate Notice of Home and Community Based Services (Waiver) Decision

	_____ _____, LA _____ _____, 20 _____ Case ID# _____ Person ID# _____ SSN _____ Provider(s) _____ _____

Dear _____:

The following decision has been made on your application or existing certification for Medicaid health care **and** provider payment coverage for the following Home and Community Based Services (HCBS) program:

☐ Adult Day Health Care ☐ Mental Retardation/Developmental Disabilities
☐ Children's Choice ☐ Personal Care Attendant
☐ Elderly & Disabled Adult

☐ Your application for Medicaid health care coverage has been approved effective _____.
Your Medicaid coverage for HCBS (waiver) has been approved effective _____.

STATE: Louisiana DATE: April 1, 2003
:

☐ You have been approved as a Qualified Medicare Beneficiary. Beginning _____, the **Medicaid Program** will pay for your Medicare premiums and deductibles, provide medically necessary ambulance transportation, and may provide the co-insurance for other Medicare-covered services if the medical services provider accepts you as a Medicaid patient. You will get a plastic Medicaid card to help pay for your medical expenses. The automated process used to pay your Medicare premiums may take up to 90 days after you are certified. You will be reimbursed by Social Security for any premiums you have paid, back to the effective month of coverage.

☐ You have been approved as a Specified Low-Income Medicare Beneficiary. Beginning _____, the **Medicaid Program** will pay **only** your Medicare Part B premiums. You **will not** receive a plastic Medicaid card. The automated process used to pay your Medicare premiums may take up to 90 days after you are certified. You will be reimbursed by Social Security for any premiums you have paid, back to the effective month of coverage.

☐ Your application for Medicaid coverage for HCBS (waiver) was not approved because _____ _____. Policy reference for our decision is _____.

☐ Your application for Medicaid health care coverage and HCBS (waiver) has not been approved because you transferred resources for less than fair market value. You will remain **ineligible** from _____ through _____, unless otherwise eligible. Once this period ends, you must contact the Bureau of Community Support & Services at 1+800+660-0488 (toll free) to be added back to the Waiver Request for Services Registry. Policy reference for our decision is _____.

☐ Medicaid payment to the provider(s) named above is being ☐ reinstated; ☐changed; ☐ terminated effective _____ because _____ _____. Policy reference for our decision is _____.

☐ Medicaid health care coverage will be closed _____because we were informed that the recipient is:

☐ no longer a Louisiana resident. ☐ deceased. Policy reference for our decision is _____.

☐ Medicaid health care coverage and HCBS (waiver) will be closed _____because we were informed that the recipient is:

☐ no longer a Louisiana resident. ☐ deceased. Policy reference for our decision is _____.

☐ Recipients under age 21 are eligible for EPSDT services, including KIDMED. KIDMED services include immunizations; vision, dental, and hearing checkups; nutrition/health education; unlimited doctor visits; medical equipment; and any other medically necessary services. You will be contacted by the KIDMED office OR you may call them toll-free at 1+800+259-4444 or 1+877+455-9955.

If you are unable to make arrangements for non-emergency medical transportation, you may call 1+800+464-6034 toll free. You must call at least 2 days before the appointment to schedule transportation.

You need to let your local Medicaid office know about changes in where you live or get your mail. You also need to report any changes in your situation. This includes changes in the income and resources (cash, property, vehicles, etc.) that you, your spouse or other dependents receive, your marital status, the number of persons who depend on you for support, and health insurance coverage. If you do not report such changes, you may get Medicaid health care/vendor payment coverage or money to which you are not entitled. You will be expected to repay any benefits received or paid on your behalf for which you are not eligible.

S
:

Sincerely,

_____
Agency Representative

_____
Phone Number

_____
Fax Number

CC ☐ Bureau of Community Support & Services
☐ _____ (Provider)
☐ _____ (Other)

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

YOUR FAIR HEARING RIGHTS

If you disagree with this decision, you may discuss it with a supervisor in the **Medicaid Program** office. The supervisor can review this decision and give you any other information you may need about the reason for this action. You may also ask for a Fair Hearing. If you want to request a Fair Hearing, you **must** do so by _____ (thirty days from the date of this notice).

You can ask for a Fair Hearing by completing and signing the section below. You may mail or deliver your request to the **Medicaid Program** office at _____ **or** you may mail it directly to the DHH Appeals Bureau at P.O. Box 4183, Baton Rouge, LA 70821-4183. If you ask for a Fair Hearing, you will get the rights to: review your case record and/or any other information the agency plans to use before the hearing; appear in person; represent yourself or have anyone else you choose to represent you; present your own evidence or witnesses; and question any person who testifies against you.

You may be able to get free legal help by calling the nearest legal assistance office at _____.

COMPLETE THIS SECTION ONLY IF YOU WANT TO REQUEST A FAIR HEARING

I want to appeal the decision on my case as shown on the front of this notice. I think it is unfair because:

Date: _____

Signature: _____
Applicant/Recipient/Representative

Phone No.: (_____)_____
Address: _____
_____

STATE: Louisiana
:

DATE: April 1, 2003

STATE: Louisiana DATE: April 1, 2003
:

BHSF Form 90-L
Rev. 11/00
Prior Issues Obsolete

REQUEST FOR MEDICAL ELIGIBILITY DETERMINATION

I. RECIPIENT INFORMATION

A. Recipient=s Name:		**SS #:**	**Medicaid #:**
B. Address (City, State, Zip Code, Parish):		**C. Responsible Party/Curator:**	
		Address (City, State, Zip Code, Parish):	
Telephone #:	**Race: Sex:**		
Medicare #:	**Date of Birth:**	**Relationship:**	**Telephone #:**

D. What are/were the living arrangements: 9 Own home 9 Relative=s home 9 Other

E. What previous institutional care (including nursing facilities) has this person received?

Facility:	**Date:**	**Facility:**	**Date:**
Facility:	**Date:**	**Facility:**	**Date:**

F. What Home/Community-based services have been used/considered: 9 ADHC 9 MR/DD 9 CC 9 PCA 9 ELDERLY 9 HH

G. Why were services not suitable?

H. Requesting Nursing Home placement: 9 Temporarily 9 Permanently

I. Applicant/Responsible Party Signature:_____Date:_____

II. LEVEL OF CARE DETERMINATION

Institutional care is provided under classifications dependent upon the type and/or complexity of care and services rendered, as well as, the amount of time required to render the necessary care and services. The attending physician must designate the required level of care by selecting the appropriate level below. This requirement also applies to applicants requesting home or community-based waiver services to allow for a determination of the level of institutional care that would otherwise be required. Please select one of the following levels of care:

A. 9 Intermediate Care II (minimum care required) - Includes some aid in activities of daily living, diversionary activities, protection from hazards and/or a minimum

B. 9 Intermediate Care I (medium care required) - Includes need for nursing care to manage a plan of care and/or more assistance with extensive personal care, ambulation, and mobilization.

C. 9 Skilled Care (maximum care required) - Indicate special level, if indicated: 9 TDC 9 ID 9 NRTP (9 Complex; 9 Rehab) Includes professional nursing care and assessment on a daily basis due to a serious condition which is unstable or a rehabilitative therapeutic regime requiring professional staff.

D. 9 ICF/MR - Requires active treatment of mental retardation or a developmental disability under supervision of a qualified mental retardation or developmental disability professional.

E. Is this person likely to need services in a medical facility (hospital, nursing facility, etc.) for at least thirty (30) consecutive days ? 9 Yes 9 No

F. Home/community based services are adequate to meet the needs of this patient. 9 Yes 9 No

G. COMMENTS:

Recipient=s Name: **III. MEDICAL INFORMATION**

A. Diagnosis:_____

_____

B. Medications:(Specify dosage, frequency, and route) ALLERGIES_____

1. _____ **5.** _____ **9.** _____

2. _____ **6.** _____ **10.** _____

3. _____ **7.** _____ **11.** _____

4. _____ **8.** _____ **12.** _____

C. Recent Hospitalizations: (include psychiatric)_____

_____

D. Mental Status/Behavior: check Yes or No. If Yes, indicate frequency: 1 = seldom; 2 = frequent; 3 = always

9 Yes (1, 2, 3) 9 No 1. Oriented	9 Yes (1, 2, 3) 9 No 4. Comatose	9 Yes (1, 2, 3) 9 No 7. Hostile
9 Yes (1, 2, 3) 9 No 2. Forgetful	9 Yes (1, 2, 3) 9 No 5. Confused	9 Yes (1, 2, 3) 9 No 8. Combative
9 Yes (1, 2, 3) 9 No 3. Depressed	9 Yes (1, 2, 3) 9 No 6. Wanders	

E. Activities of Daily Living: (check appropriate box)

SELF	ASSIST	TOTAL			
9	9	9	1. Eating	9 11. Verbal	9 16. Impaired vision _____
9	9	9	2. Bathing	9 12. Non-verbal	9 Glasses
9	9	9	3. Personal	9 13. Bowel Incontinence	9 17. Impaired hearing_____
9	9	9	4. Oral Hygiene	9 14. Bladder Incontinence	9 Hearing Aid
9	9	9	5. Ambulation	9 15. Urinary Catheter	9 18. Dentures _____

F. SPECIAL CARE/PROCEDURES: (check appropriate box: when appropriate give type, frequency, size, stage and site)

9 1. Ostomy care_____ **9 7. MRSA**_____

9 2. Glucose Monitoring_____ **9 8. Diet/Tube Feeding**_____

9 3. Restraints _____ **9 9. Dialysis**_____

9 4. IV=s_____ **9 10. Respiratory** _____

9 5. Suctioning_____ **9 11. Decubitus**_____

9 6. Specialized Rehab_____ **9 12. Other**_____

G. PHYSICAL EXAMINATION: Height_____**Weight**_____**Pulse**_____**Resp**_____**Temp**_____**B/P**_____
Lab Results: HCT_____**HGB**_____**U/A**_____**Radiology**_____

General_____**Head and CNS**_____

Mouth and EENT_____ **Chest**_____

Heart and Circulation_____ **Abdomen**_____

Genitalia_____ **Extremities**_____

Skin_____ **Other**_____

H. Physician=s Name (Type or Print)_____ **PHONE**_____
Address:_____
Physician=s Signature_____ **Date**_____

BHSF Form LTC/CS
Rev. 02/02
Prior Issue Obsolete
II

LOUISIANA MEDICAID
LONG TERM CARE CHOICE OF SERVICE

Name_____ SS#_____ Contact Date_____ Time ___:___

Mailing Address_____ Parish_____

Telephone Number (_____)_____ Date of Birth _____ Sex _____

Louisiana Medicaid offers **two** distinct settings for persons requesting Long-term Care services. One is a facility setting. This includes nursing facility or ICF/MR facility care. The other setting is Home and Community-Based waiver Services (HCBS).

A HCBS "Waiver" gives you a choice to receive Medicaid services in your home and community rather than receiving care in a nursing facility. It is the ultimate goal of the department to allow recipients to make an informed choice of setting in which to receive Medicaid services. Along those lines, **YOU** have the freedom to choose between a nursing facility or a community-based setting.

At the current time there may not be enough slots available in order to provide services to you in the community. If you choose community services, you will be placed on a registry for the appropriate waiver. While you wait for a slot to open, you **may be eligible** to receive appropriate services in a nursing facility. In any regard, your choice will not have a negative impact on your receipt of nursing facility services if these are needed while you wait for community placement. Also, your level of care may not make community placement appropriate for you.

If you wish to be assessed for community services, please let us know. The Department of Health and Hospitals, Bureau of Community Support & Services will contact you for an assessment.

CHOICE OF SERVICE

Select one of the following choices:

❑ A. My choice of service is Nursing Facility or ICF/MR Facility care.

❑ B. My choice of service is HCBS and I would like more information about these services, but I will accept Nursing Facility or ICF/MR Facility care until HCBS is available for me.

❑ C. My only choice of service is HCBS and I would like more information about these services.

If item B or C above is selected, please complete the following information.

1. Do you need someone to be with you when answering questions or receiving information? ❑ Yes ❑ No
2. Do you think that you are likely to require admission to a nursing home in the next 120 days? ❑ Yes ❑ No
3. Do you have a mental or physical condition(s) that require immediate attention? ❑ Yes ❑ No

_____ _____

STATE: Louisiana DATE: April 1, 2003
:

Signature of Potential Nursing Facility or Waiver Recipient

Signature of Person Assisting with Completion of Form

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

___ Registered nurse, licensed to practice in the State

___ Licensed practical or vocational nurse, acting within the scope of practice under State law

___ Physician (M.D. or D.O.) licensed to practice in the State

___ Social Worker (qualifications attached to this Appendix)

T Case Manager is responsible for documenting (writing) the plan of care, submitting it to BCSS for approval, and distributing the approved plan to the provider and family. The case management agency convenes an interdisciplinary team to develop the plan of care. The team may include professionals, providers, advocates, and the client/family as appropriate for that individual. The exact composition of the team depends on the challenges faced by the individuals. Participation on the team may be by report.

___ Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

___ At the Medicaid agency central office

___ At the Medicaid agency county/regional offices

T By case managers

T By the agency specified in Appendix A

___ By consumers

__ Other (specify):

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

___ Every 3 months

___ Every 6 months

T Every 12 months

___ Other (specify):

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

Comprehensive Plans of care are completed by the enrolled case management provider for each recipient according to person centered principles as a result of a meeting of the interdisciplinary planning team, which may include professionals, providers, advocates, and the client/family as appropriate for that individual. Members of that team sign the care plan which is forwarded to the regional staff of the Bureau of Community Supports and Services (BCSS) for review and approval of level of care and appropriateness of planned services. Every plan of care is reviewed by BCSS prior to determining whether the applicant is eligible for waiver services and at least annually thereafter. Any changes to the plan of care are proposed by the planning team and must also be approved by BCSS. Approved waiver services are monitored electronically to assure that unauthorized services are not billed. A 5% sample is reviewed by BCSS Quality Management Team annually to determine that services are utilized as approved.

Please note: The single state agency is Department of Health and Hospitals (DHH). BCSS is a part of DHH.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, *outcomes*, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

Please note: The CPOC form is used for all Louisiana=s waivers and case management plans of care.

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF COMMUNITY SUPPORTS & SERVICES
NEW OPPORTUNITIES WAIVER (NOW)
COMPREHENSIVE PLAN OF CARE
CONFIDENTIAL

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF COMMUNITY SUPPORTS & SERVICES
NEW OPPORTUNITIES WAIVER (NOW)
COMPREHENSIVE PLAN OF CARE
CONFIDENTIAL

TYPE: ☐ INITIAL ☐ ANNUAL WAIVER: ■ NOW LEVEL OF CARE: ■ ICFMR

INDIVIDUAL'S NAME		LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE	
SOCIAL SECURITY NUMBER	DOB / /	RELATIONSHIP	
MEDICAID #	MEDICARE #	LEGAL STATUS: ☐ MINOR ☐ INTERDICTED ☐ POWER OF ATTORNEY ☐ COMPETENT MAJOR ☐ OTHER _____	
ADDRESS (PHYSICAL)	MAILING (IF DIFFERENT)	ADDRESS (PHYSICAL)	MAILING (IF DIFFERENT)
CITY/STATE/ZIP CODE	PARISH	CITY/STATE/ZIP CODE	PARISH
DAY PHONE	NIGHT PHONE	DAY PHONE	NIGHT PHONE
CASE MANAGEMENT AGENCY (**NO ABBREVIATIONS**)		PROVIDER NUMBER	
CASE MANAGEMENT AGENCY ADDRESS		CONTACT PERSON (**CASE MANAGER**)	
CITY/STATE/ZIP CODE		TELEPHONE NUMBER	

SEX: ☐ MALE ☐ FEMALE **ETHNICITY:** ☐ AFRICAN-AMERICAN ☐ CAUCASIAN ☐ HISPANIC ☐ ASIAN ☐ OTHER

EDUCATION: ☐ ATTENDS SCHOOL ☐ HOMEBOUND ☐ N/A

PRIMARY DISABILITY/DIAGNOSIS: _____ **DATE OF ONSET:** / /

SECONDARY DISABILITY/DIAGNOSIS: _____ **DATE OF ONSET:** / /

MR: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND ☐ OTHER _____

ADAPTIVE FUNCTIONING: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND **AMBULATION:** ☐ YES ☐ NO ☐ OTHER

SIL: ☐ YES ☐ NO **24-HOUR SERVICE:** ☐ YES ☐ NO **MOBILE WITH ASSISTIVE DEVICES:** ☐ YES ☐ NO

EMERGENCY SELF-EVACUATE: ☐ YES ☐ NO **ATTACH INDIVIDUALIZED EMERGENCY EVALUATION/RESPONSE PLAN**

EMERGENCY RESPONSE: ☐ **LEVEL 1** TOTAL ASSISTANCE WITH LIFE SUSTAINING EQUIPMENT ☐ **LEVEL 2** TOTAL ASSISTANCE
☐ **LEVEL 3** CAN RESPOND/NEEDS TRANSPORTATION ☐ **LEVEL 4** CAN RESPOND INDEPENDENTLY

WILL RESIDENCE CHANGE WITH WAIVER PARTICIPATION? ☐ YES ☐ NO IF YES, WHEN & PROPOSED ADDRESS?

IS THIS A TRANSITION FROM A DEVELOPMENTAL CENTER OR NURSING FACILITY? ☐ YES ☐ NO DEPOSIT REQUIRED? ☐ YES ☐ NO

ARE THERE MULTIPLE WAIVER RECIPIENTS IN THE HOME? ☐ YES ☐ NO IF SO, HOW MANY? _____

ARE THERE MULTIPLE INDIVIDUALS WITH DISABILITIES (NON-RECIPIENT) IN THE HOME? ☐ YES ☐ NO IF SO, HOW MANY? _____

ARE PAID CARE GIVERS RELATED TO INDIVIDUAL? ☐ YES ☐ NO IF YES, RELATIONSHIP & SERVICE PROVIDED

DO PAID CARE GIVERS LIVE WITH RECIPIENT? ☐ YES ☐ NO IF YES, NAME & SERVICE(S) _____

DOES INDIVIDUAL RECEIVE HOME HEALTH SERVICE ? ☐ NO ☐ YES IF YES, ATTACH A HOME HEALTH PLAN.

PRESENT HOUSING ☐ OWN HOME (ALONE) ☐ OWN HOME (WITH PARTNER) ☐ OWN HOME (WITH OTHERS) ☐ OTHER'S HOME **ANTICIPATED HOUSING:**	☐ ICF/MR	☐ NURSING FACILITY	**RENT HOME**: ☐ WITH SUBSIDY ☐ WITHOUT SUBSIDY **RENT APARTMENT:** ☐ WITH SUBSIDY ☐ WITHOUT SUBSIDY

FOR BCSS USE ONLY: HIGH RISK RECIPIENT? ☐ YES ☐ NO (IF YES, BCSS WILL ADD TO HIGH RISK TRACKING)

CPOC BEGIN DATE: _____ CPOC END DATE:_____

SECTION I: EMERGENCY INFORMATION Confidential

ATTACH INDIVIDUALIZED EMERGENCY EVACUATION/RESPONSE PLAN

INDIVIDUAL'S NAME: _____ **AGE:** _____

ADDRESS: _____

DIRECTIONS TO MY HOME: _____

PERSON RESPONSIBLE FOR EVACUATING/BRINGING SUPPLIES TO INDIVIDUAL'S HOME:

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____

FAMILY MEMBERS/OTHER TO CONTACT IN CASE OF EMERGENCY (INCLUDING PROVIDERS):

1. NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS _____

2. NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____

3. NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS _____

EMERGENCY EQUIPMENT IN HOME:

☐ FIRE EXTINGUISHER: LOCATION _____ ☐ FIRST AID KIT: LOCATION _____

☐ HOME EVACUATION PLAN: LOCATION: _____ ☐ SPECIALIZED MEDICAL EQUIPMENT: LOCATION _____

☐ SMOKE DETECTORS ☐ OTHER _____

SPECIAL CONSIDERATIONS/NECESSITIES (DETAILED INFORMATION REQUIRED): UTILIZES ASSISTIVE TECHNOLOGY, DEPENDENT ON VENTILATOR, MEDICATIONS, ETC. (SEE INDIVIDUAL EMERGENCY EVACUATION/RESPONSE PLAN)

DOCTOR'S NAME: _____ PRIMARY: _____ PHONE: _____

DOCTOR'S NAME: _____ SPECIALTY: _____ PHONE: _____

DOCTOR'S NAME: _____ SPECIALTY: _____ PHONE: _____

NAME: _____

A. HEALTH STATUS

1. **PHYSICAL (e.g., GENERAL HEALTH, MOBILITY, ASSISTIVE DEVICES):**

2. **ALLERGIES (e.g., MEDICATION, FOOD, ENVIRONMENTAL):**

DESCRIBE WHAT HAPPENS WHEN THERE IS AN ALLERGIC REACTION

3. **MEDICAL DIAGNOSES/SIGNIFICANT MEDICAL HISTORY/CONCERNS:**

4. **DOCTOR VISITS (PAST YEAR AND SCHEDULED VISITS):**

5. **PSYCHIATRIC/BEHAVIOR CONCERNS:**

6. **BEHAVIOR SUPPORT PLAN ATTACHED (IF NEEDED):** ☐ YES ☐ NO

7. **INCIDENT REPORTS (FOR PAST 6 MONTHS):**

A. CRITICAL INCIDENTS
   1. UNPLANNED HOSPITAL #
   2. ER VISITS #
   3. PSYCHIATRIC ADMITS #
   4. ABUSE/NEGLECT #

B. NON-CRITICAL INCIDENTS #

C. HOSPITAL ADMISSIONS #

D. EMERGENCY DOCTOR VISITS #

E. PSYCHIATRIC HOSPITAL ADMISSIONS #

ADDITIONAL INFORMATION/SUMMARY:

NAME: _____

B. LIST OF MEDICATIONS: (INCLUDING OVER THE COUNTER MEDICATIONS) Confidential

MEDICATIONS	WHAT IS IT FOR?	DOSAGE/FREQUENCY	HOW IS IT TAKEN?	PRESCRIBING PHYSICIAN *(CHECK BOX IF PHYSICIAN DELEGATION IS NEEDED)	To Be Given by: (SELF, FAMILY, STAFF, CMA, CNA, ETC.)
1.				☐	
2.				☐	
3.				☐	
4.				☐	
5.				☐	
6.				☐	
7.				☐	
8.				☐	
9.				☐	
10.				☐	

C. LIST OF TREATMENTS (e.g. CATHERIZATIONS, TUBE FEEDING, DRESSING CHANGES, SUCTIONING, OXYGEN, SPLINTS, BRACES, ETC.)

TREATMENTS	WHAT IS IT FOR?	FREQUENCY	HOW IS IT PERFORMED?	PRESCRIBING PHYSICIAN *(CHECK BOX IF PHYSICIAN DELEGATION IS NEEDED)	To Be Given by: (SELF, FAMILY, STAFF, CMA, CNA, ETC.)
1.				☐	
2.				☐	
3.				☐	
4.				☐	
5.				☐	

NAME: _____

SECTION III. ALL ABOUT ME

Confidential

Information included in this section is relevant to my life today and is my way of sharing social/family history with you. I hope that this information will be helpful in assisting you to help me achieve my personal outcomes. My personal outcomes worksheet (see attached Personal Outcomes Worksheets) will assist you in helping me tell you about myself. If I need assistance telling my story, please ask those who know me best.

A. HISTORICAL INFORMATION: Information in this section includes historical issues, for example, nature and cause of person's disability, person's age at onset of disability (if not know, please indicate by writing "unknown" in this section), education, work history; recurring situations that impact support needs; summary of events leading to request for support at this time.

B. CURRENT LIVING SITUATION: Information in this section includes family's involvement and understanding of individual's strengths, skills and abilities, current issues/situations that may present barriers to individual obtaining supports and services they desire, individual's/family/circle of support knowledge of disability and how individual wants to be supported; economic issues, including current employment; connections to community and natural supports, relationships/friends/family/other, where and with whom individual lives, rural/urban area, accessibility to resources, own home/rents/lives with relative/extended family/alone, does physical home environment meet accessibility/safety needs, health and age of family care-givers (if supported by family), feelings of safety and continuity of supports/care, etc.

C. CURRENT COMMUNITY SUPPORTS OR OTHER AGENCY INVOLVEMENT: Information in this section includes significant life events, including family issues, social/law enforcement issues, social services caseworker or Probation Officer involvement which may require interaction with legal/social agencies, current community supports and resources being utilized, etc.

NAME: _____

A. My gifts and talents:
B. I communicate best by (speaking, gesturing, communication board, sign language, behaving in certain ways, etc.):
C. I understand best when (shown and told how, shown, use hand-over hand techniques, etc.):
D. I need help with:
E. When I am scared I need someone to:
F. When I am angry I need you to:
G. Things that work/things I like (favorite things such as…food hobbies, past time):
H. Things that don't work/things I dislike:
I. Other things I'd like you to know about me:

NAME: _____

SECTION V: IDENTIFIED SERVICES, NEEDS, AND SUPPORTS

Identified services and supports that will help me maintain and/or achieve my personal outcomes.

NOW WAIVER	NOW WAIVER	STATE-FUNDED SERVICES	NON-WAIVER SUPPORT
☐ INDIVIDUAL/FAMILY SUPPORT (IFS)	☐ **SUPPORTED EMPLOYMENT**	☐ DENTAL	
☐ IFS Night Supports	☐ ONE ON ONE	☐ DME	
☐ SHARED SUPPORTS	☐ FOLLOW ALONG	☐ EYE GLASSES	
☐ COMMUNITY INTEGRATION DEVELOPMENT	☐ MOBILE CREW	☐ HEARING AIDS	
☐ RESIDENTIAL HABILITATION/SIL	☐ TRANSPORTATION – REG	☐ HOME HEALTH	
☐ SUBSTITUTE FAMILY CARE	☐ TRANSPORTATION – W/C	☐ HOME HEALTH EXTENDED	
☐ CENTER-BASED RESPITE	☐ EMPLOYMENT-RELATED TRAINING	☐ HOSPICE	
☐ PROFESSIONAL CONSULTATION	☐ DAY HABILITATION	☐ MEDICAL TRANSPORTATION	
☐ PROFESSIONAL SERVICES	☐ DAY HAB/EMPLOYMENT-RELATED TRAINING SERVICES TRANSPORTATION	☐ MENTAL HEALTH	
☐ TRANSITION PROFESSIONAL SUPPORT	☐ TRANSPORTATION – REG	☐ PODIATRY SERVICES	
☐ SKILLED NURSING SERVICES	☐ TRANSPORTATION – W/C	☐ SUBSTANCE ABUSE	
☐ ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS		☐ OTHERS	
☐ Specialized Medical Equipment and Supplies			
☐ Personal Emergency Response System (PERS)			
☐ One-Time Transitional Support			

(NOTE: INFORM INDIVIDUAL OF ALL STATE PLAN SERVICES. CASE MANAGER INITIALS: _____)

NAME: _____

NOTE: Planning must include and reflect emergency backup plans where the health and welfare of the recipient may be adversely affected.

MY PERSONAL OUTCOMES	SUPPORT STRATEGY NEEDED	HOW OFTEN FOR SUPPORTS AND SERVICES	REVIEW/ACCOMPLISHED DATE	
What I want for myself. What is important to me right now? What do I want /expect as a result of supports and services?	What I need to achieve my personal outcomes. How will services and supports be provided to me? Who will deliver the services and supports (Paid/unpaid)? Where will services and supports be provided? What (if any) assistive devices will be required? **Be Specific**	How and when (how often) do I want services and supports provided? **Be Specific**	When/how often will the supports and services be reviewed. When was the personal outcome accomplished/achieved? Is this still an outcome I want in my life now? Has anything changed in my life that needs to be addressed at this time? **Be Specific**	
			REVIEW DATE	**ACCOMPLISHED**

NAME: _____

SECTION VII: TYPICAL WEEKLY SCHEDULE

Confidential

FOR PLANNING PURPOSES ONLY. IF NEEDS CHANGE, I WILL CONTACT MY CASE MANAGER AS SOON AS POSSIBLE.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12:00 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							

CODE	HOURS
F = FAMILY	
FR = FRIENDS	
S = SELF	
SC = SCHOOL	
C = COMPANION	
PW = PAID WAIVER	
P = PAID SUPPORT	
TOTAL	

COMMENTS:

* FOR ALL PW SERVICES IDENTIFY – EXAMPLE = PW-IFS

NAME: _____

SECTION VIII: ALTERNATE SCHEDULE

Confidential

FOR PLANNING PURPOSES ONLY. IF NEEDS CHANGE, I WILL CONTACT MY CASE MANAGER AS SOON AS POSSIBLE.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12:00 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							

CODE	HOURS
F = FAMILY	
FR = FRIENDS	
S = SELF	
SC = SCHOOL	
C = COMPANION	
*PW = PAID WAIVER	
P = PAID SUPPORT	
TOTAL	

COMMENTS:

* FOR ALL PW SERVICES IDENTIFY – EXAMPLE = PW-IFS

NAME: _____

SECTION IX: CPOC REQUESTED WAIVER SERVICES (BUDGET SHEET) – TYPICAL WEEK SCHEDULE

List the individual's requested services as described in the CPOC.

Date of Request: _____

1. Provider Name (Full Name -No Acronyms)	2. Provider Number	3. Service Type	4. Procedure Codes	5. Number of Units	6. Cost/Units	7. Yearly/ Annual Costs
			Annual Totals:			

***PROVIDER REPRESENTATIVE SIGNATURE:** _____AGENCY:_____**DATE:**_____
*PROVIDER REPRESENTATIVE SIGNTURE:_____AGENCY:_____DATE:_____

***I HAVE REVIEWED THE CPOC AND AGREE TO PROVIDE THE ABOVE STATED SERVICES.**

BCSS APPROVAL SIGNATURE/TITLE:_____ __ **DATE:** _____

NAME: _____

SSN #: _____

DAILY SERVICE TOTALS

CONFIDENTIAL

PROCEDURE CODES (FROM COLUMN 4 ON BUDGET SHEET)	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	WEEKLY TOTALS (UNITS OF SERVICE IN COLUMN 5 OF BUDGET SHEET)

ADDITIONAL UNITS OF SERVICE PER QUARTER – ALTERNATIVE SCHEDULE

PROCEDURE CODES (FROM COLUMN 4 ON BUDGET SHEET)	JANUARY – MARCH		APRIL – JUNE		JULY – SEPTEMBER		OCTOBER - DECEMBER	
	UNITS	PURPOSE	UNITS	PURPOSE	UNITS	PURPOSE	UNITS	PURPOSE

*PROVIDER REPRESENTATIVE SIGNATURE:_____ AGENCY:_____ DATE:_____

*PROVIDER REPRESENTATIVE SIGNATURE:_____ AGENCY:_____ DATE:_____ __ __

*I HAVE REVIEWED THE CPOC AND AGREE TO PROVIDE THE ABOVE STATED SERVICES.

DATE:

BCSS APPROVAL SIGNATURE: _____ _____

NAME: _____

SECTION X: CPOC PARTICIPANTS

Confidential

PARTICIPANTS MUST SIGN THAT THEY PARTICIPATED IN THE PLANNING MEETING.

PLANNING PARTICIPANTS	Relationship

_____ _____

CASE MANAGER Date

I have reviewed the services contained in this plan. I choose to accept this plan and the services described instead of the alternatives explained or offered to me. I understand it is my responsibility to notify the case manager of any change in my status, which might affect the effectiveness of this program. I further agree to notify the case manager of any changes in my income, which might affect my financial eligibility. I understand that I have the right to accept or refuse all or part of the services identified in this support plan.

I have been informed of my rights and responsibilities regarding the HCB Waiver Services and have been given the Rights and Responsibilities Form, BCSS. _____ (**Recipient's/Authorized Representative's Initials)**

I understand that if I disagree with any decision rendered regarding the approval of this plan, I have the right to an informal discussion with BCSS and/or a fair hearing by the DHH Appeals Bureau within 30 days of the approved/denied decision. Contact your BCSS Regional Office for an informal discussion. I understand that a DHH Appeals Bureau Fair Hearing may be requested by contacting the DHH Bureau of Appeals, P.O. Box 4183, Baton Rouge, LA 70821-4183.

I have been informed of all state plan services _____ (**Recipient's/Authorized Representative's Initials)**

_____ _____

RECIPIENT'S SIGNATURE/GUARDIAN SIGNATURE **DATE**

_____ _____

WITNESS **DATE**

REVIEWED BY CASE MANAGER SUPERVISOR SIGNATURE/TITLE:_____ **DATE:**_____

RECIPIENT'S NAME: _____ **PROGRAM TYPE:** **NEW OPPORTUNITIES WAIVER**

DATE COMPLETE CPOC RECEIVED IN BCSS RO: _____

THIS CPOC MEETS THE IDENTIFIED NEEDS OF THE INDIVIDUAL: ☐ **APPROVED** ☐ **DENIED**

WITHOUT THE SERVICES AVAILABLE THROUGH THIS WAIVER, THE RECIPIENT WOULD QUALIFY FOR INSTITUTIONAL CARE: ☐ YES ☐ NO

APPROVED CPOC BEGIN DATE: _____ **APPROVED CPOC END DATE** _____

SERVICES APPROVED:

SIGNATURE/TITLE OF BCSS REPRESENTATIVE: **DATE:**

NAME: _____

PERSONAL OUTCOMES WORKSHEETS
(Required as part of CPOC)

NAME: _____

	CURRENT LIFE SITUATION	CURRENT SUPPORT SITUATION – NATURAL AND PAID (WHAT'S GOING ON THAT SUPPORTS MY DESIRED OUTCOME?)	Current Level of Satisfaction (1 TO 5 SCALE)
IDENTITY – "WHO AM I?"			
1. What Goals have I set for myself? 2. Where and with who do I want to live? 3. What do I want to do for my work? 4. Who is closest to me? 5. How satisfied am I with the services and supports I receive? 6. How satisfied am I with my personal life situation?			
AUTONOMY – "MY SPACE"			
7. What are my preferred daily routines? 8. Do I have the time, space, and opportunity for the privacy I need? 9. Am I in control of who knows personal information about me? 10. Do my home, work, and other environments support what I want and need to be?			
AFFILIATION – "MY COMMUNITY"			
11. Do I have access to the place I want to be? 12. Do I participate in what happens in my community? 13. Am I pleased with the type and extent of my interaction with other people in my community? 14. Am I known for the different social roles I play? 15. Do I have enough friends? 16. Am I respected by others?			
ATTAINMENT – "MY SUCCESS"			
17. Are the supports and services I receive the ones I want? 18. Have I realized any of my personal goals?			
SAFE GUARDS – "MY SAFE GUARDS"			
19. Am I connected to the people who support me the most? 20. Am I safe?			
RIGHTS – "MY RIGHTS"			
21. Do I exercise the rights that are important to me? 22. Do I feel that I am treated fairly?			
HEALTH AND WELLNESS – "MY HEALTH"			
23. Is my health as good as I can make it? 24. Am I free from Abuse and Neglect? 25. Do I have a sense of continuity and security?			

CURRENT LEVEL OF SATISFACTION:

1 – NOT AT ALL SATISIFIED
2 – NOT VERY SATISFIED
3 – SOMEWHAT SATISFIED
4 – SATISFIED
5 – VERY SATISFIED

NAME: _____

Personal Outcomes Importance and Satisfaction:

Choose how important each Personal Outcome is to you.

Choose how satisfied you are with each Personal Outcome.

For each question, check the box that best describes your answer.

	Not at All	Somewhat	Very
How important is choosing where and with whom you live?			
How satisfied are you with where and with whom you live?			
How important is it for you to feel respected?			
How satisfied are you with how respected you feel?			
How important is choosing where you work?			
How satisfied are you with your work situation?			
How important is being satisfied with your personal life situation?			
How satisfied are you with your personal life situation?			
How important is interacting with other members of the community?			
How satisfied are you with interaction in the community?			
How important is it for you to have intimate relationships?			
How important is choosing your daily routine?			
How satisfied are you with your daily routine?			

NAME: _____

Top 3 Personal Outcomes/Goals

Look at the Personal Outcomes Worksheet, Personal Outcomes Importance and Satisfaction Worksheet, as well as other information that will help you in choosing at least three things you would like to see change, improve or maintain in your life right now (Copy this form as needed) . What matters to you the most?

Use the space below to help you with identifying what matters the most to you in your life right now, and then decide what help/support you need to get what you want.

OUTCOME/GOAL # _____

I want (my desired outcome/goal):

What is currently in place to support/help me get what I want?

What are some barriers that may keep me from getting what I want? (Things/actions that move me further away from what I want):

What do I need to help me get what I want (reach my desired outcome/goal)?

NAME: _____

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

T Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

____ Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

   a. When the individual was eligible for Medicaid waiver payment on the date of service;

   b. When the service was included in the approved plan of care;

   c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

      T Yes

      ___ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

   T All claims are processed through an approved MMIS.

   ___ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

____ The Medicaid agency will make payments directly to providers of waiver services.

__T__ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

__T__ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

____ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: *ICF/MR*

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	$44,459	$5,287	$60,872	$4,341
2	$46,952	$5,287	$60,872	$4,341
3	$49,363	$5,287	$60,872	$4,341
4				
5				

STATE: Louisiana DATE April 1, 2003

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR		UNDUPLICATED INDIVIDUALS
1		4,251
2	+325	4,576
3	+200	4,776
4		
5		

EXPLANATION OF FACTOR C:

Check one:

____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

__T__ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period *or the number who can be served with the appropriated budget*.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: *ICF/MR*

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2
FACTOR D
LOC: *ICF/MR*

Demonstration of Factor D estimates:

Waiver Year 1 T 2 3 4 5

Waiver Service Column A		# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
1. Individualized and Family Support		4,114	3,382 hours	$10.99/hr	$152,909,892
2. Residential Habilitation /Supervised Independent Living		1,420	316 days	$20.00/day	$8,974,400
3. Skilled Nursing Services		84	4,380 hours	$24.50/hr	$9,014,040
4. Professional Services	RN & LPN	850	30 hours	$24.52/hour	$625,260
	Social Work	850	8 hours	$37.52/hour	$255,136
	Psychologist	1700	4 hours	$75.00/hour	$510,000
5. Community Integration Development		208	60 hours	$10.99/hour	$137,155
6. Transitional Professional Support Services		241	158 hours	$40.38/hour	$1,537,590
7. Professional Consultation	RN	850	7 hours	$24.52/hour	$145,894
	Social Work	850	8 hours	$37.52/hour	$255,136
	Psychologist	1700	4 hours	$75.00/hour	$510,000
8. Personal Emergency Response System (PERS)		98	12 month	$27.00/month	$31,752
9. Environmental Accessibility Adaptations		196	8 adaptations	$886.35	$1,389,797
10. Specialized Medical Equipment and Supplies		36	1 equipment	$2,854.72	$102,797
11. Substitute Family Care		70	294 days	$39.00 day	$802,620
12. Respite (Center Based)		97	528 hours	$11.50/ hour	$588,984
13. Supported Employment		686	260 day	$28.17/day	$5,024,401
14. Day Habilitation		355	563 hours	$6.50/hour	$1,299,122

STATE: Louisiana Date: April 1, 2003

15. Habilitation Day/Vocational Transportation	310	240 day	$16.00/day	$1,190,400
16. Employment Related Training	638	843 hours	$6.50/hour	$3,495,921
17. Transition Start-up	65	1 time expense	$3,000.00	$195,000
GRAND TOTAL (sum of Column E)				$188,995,297
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				4,251
FACTOR D (Divide total by number of recipients):				$44,459
AVERAGE LENGTH OF STAY: 300				

APPENDIX G-2
FACTOR D
LOC: *ICF/MR*
Demonstration of Factor D estimates:
Waiver Year 1___ 2 T__ 3___ 4___ 5

Waiver Service Column A		# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
1. Individualized and Family Support		4,428	3,518 hours	$10.99/hour	$171,198,966
2. Residential Habilitation /Supervised Independent Living		1,529	328 days	$20.00/day	$10,030,240
3. Skilled Nursing Services		108	4,555 hours	$24.50/hour	$12,052,530
4. Professional Services	RN & LPN	850	30 hours	$24.52/hour	$625,260
	Social Work	850	8 hours	$37.52/hour	$255,136
	Psychologist	1700	4 hours	$75.00/hour	$510,000
5. Community Integration Development		224	62 hours	$10.99/hour	$152,629
6. Transitional Professional Support Services		319	165/hour	$64.06/hour	$3,371,798
7. Professional Consultation	RN	850	7 hours	$24.52/hour	$145,894
	Social Work	850	8 hours	$37.52/hour	$255,136
	Psychologist	1700	4 hours	$75.00/hour	$510,000
8. Personal Emergency Response System (PERS)		106	12 months	$27.00/monthly	$34,344
9. Environmental Accessibility Adaptations		211	8 adaptations	$886.35	$1,496,158
10. Specialized Medical Equipment and Supplies		39	1 equipment	$2,854.72	$111,334
11. Substitute Family Care		76	305 days	$39.00/day	$904,020
12. Respite (Center Based)		104	550 hours	$11.50/hour	$657,800
13. Supported Employment		769	260 days	$28.17/day	$5,632,309

Waiver Service Column A	# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
14. Day Habilitation	382	585 hours	$6.50/hour	$1,452,555
15. Habilitation Day/Vocational Transportation	334	250 days	$16.00/day	$1,336,000
16. Employment Related Training	686	877/hours	$6.50/hour	$3,910,543
17. Transition Start-up	70	1 time expense	$3,000.00	$210,000
GRAND TOTAL (sum of Column E)				$214,852,652(
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				4,576
FACTOR D (Divide total by number of recipients):				$46,952
AVERAGE LENGTH OF STAY: 326				

APPENDIX G-2
FACTOR D
LOC: *ICF/MR*
Demonstration of Factor D estimates:
Waiver Year 1___ 2__ 3 T__ 4__ 5

Waiver Service Column A		# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
1. Individualized and Family Support		4,622	3,658 hours	$10.99/hour	$185,810,963
2. Residential Habilitation /Supervised Independent Living		1,596	341 days	$20.00/day	$10,884,720
3. Skilled Nursing Services		132	4,737/hours	$24.50/hour	$15,319,458
4. Professional Services	RN & LPN	850	30 hours	$24.52/hour	$625,260
	Social Work	850	8 hours	$37.52/hour	$255,136
	Psychologist	1700	4 hours	$75.00/hour	$510,000
5. Community Integration Development		234	65 hours	$10.99/hour	$167,157
6. Transitional Professional Support Services		391	171 hours	$64.06/hour	$4,283,115
7. Professional Consultation	RN	850	7 hours	$24.52/hour	$145,894
	Social Work	850	8 hours	$37.52/hour	$255,136
	Psychologist	1700	4 hours	$75.00/hour	$510,000
8. Personal Emergency Response System (PERS)		110	12 months	$27.00/monthly	$35,640
9. Environmental Accessibility Adaptations		220	8 adaptations	$886.35	$1,559,976
10. Specialized Medical Equipment and Supplies		41	1 equipment	$2,854.72	$117,043
11. Substitute Family Care		79	318 days	$39.00/day	$979,758
12. Respite (Center Based)		109	572 hours	$11.50/hour	$717,002
13. Supported Employment		832	260 days	$28.17/day	$6,093,734

14. Day Habilitation	399	608 hours	$6.50/hours	$1,576,848
15. Habilitation Day/Vocational Transportation	348	260 hours	$16.00/hour	$1,447,680
16. Employment Related Training	716	912 hours	$6.50/hour	$4,244,448
17. Transition Start-up	73	1 time expense	$3,000.00	$219,000
GRAND TOTAL (sum of Column E)				$235,757,968(
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				4,776
FACTOR D (Divide total by number of recipients):				$49,363
AVERAGE LENGTH OF STAY: 326				

APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

1. Substitute Family Care
2. Center based Respite
3. Residential Habilitation/Supervised Independent Living – Individuals receiving services under supervised independent living reside in their own homes and are supported through services designed to assist in acquisition, retention or training to increase recipient's independence and integration in community life.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

No wavier services, except foster care/substitute family care, are furnished in the home of a paid caregiver, as this is in direct violation with Louisiana's licensing regulations.

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

As stipulated in Appendix B's Definition of Services, calculations for these services are based on historically information regarding rates, input from key state holders, that help develop the waiver and review of national trends. Rates and per diem paid for substitute family care services, center based respite, and residential habilitation/supervised independent living do not include payments for room and board as evidenced by the low rate per hour for each of these services. The $39 per diem ($1.62 per hour) for Substitute family care, the $11.50 per hour for center-based respite, and $20 per diem (.83 cents an hour) for Residential habilitaion/supervised independent living. The cost of room and board are paid by the participant through an arrangement with the participant and the service provider to cover the room and board through the participants' SSI with allowances made for personal needs.

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

__ The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: *ICF/MR*

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

__ Based on HCFA Form 372 for years 1 of waiver
0200.09R1, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

___ Other (specify):

APPENDIX G-6

FACTOR G

LOC: *ICF/MR*

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

__ Based on trends shown by HCFA Form 372 for years 1 of waiver # 0200.09R1, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

___ Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: *ICF/MR*

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

LOC: *ICF/MR*

Factor G' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

____ Based on HCFA Form 372 for years 1 of waiver
0200.09R1, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

____ Other (specify):

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: *ICF/MR*

YEAR 1

FACTOR D:	$44,459		FACTOR G:	$60,872
FACTOR D':	$ 5,287		FACTOR G':	$ 4,341
TOTAL:	$49, 746	≤	TOTAL:	$65,213

YEAR 2

FACTOR D:	$46,952		FACTOR G:	$60,872
FACTOR D':	$ 5,287		FACTOR G':	$4,341
TOTAL:	$52,239	≤	TOTAL:	$65,213

YEAR 3

FACTOR D:	$49,363		FACTOR G:	$60,872
FACTOR D':	$ 5,287		FACTOR G':	$4,341
TOTAL:	$54,650	≤	TOTAL:	$65,213

STATE: Louisiana

Date: April 1, 2003

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC: *ICF/MR* *Years 4 and 5 are not applicable for initial waiver.*

YEAR 4

FACTOR D:	_____		FACTOR G:
FACTOR D':	_____		FACTOR G':
TOTAL:	_____	≤	TOTAL:

YEAR 5

FACTOR D:	_____		FACTOR G:
FACTOR D':	_____		FACTOR G':
TOTAL:	_____	≤	TOTAL:

2700.6 (cont.) STATE ORGANIZATION AND GENERAL ADMINISTRATION 0/95

Annual Report on Home and Community-Based Services Waivers (EXHIBIT B)

State Louisiana

Department of Heath and Human Services
Health Care Financing Administration
Form Approved OMB No.
Expires

Reporting Period July 1, 2001 – June 31, 2002

Waiver Number 0200 Waiver Year 1 2 3 Renewal Year 1 2 3 4 5

Waiver Title MR/DD

Initial Report _____ Lag Report X

Level/s of Care in Approved Waiver	ICF/MR		

ANNUAL NUMBER OF SECTION 1915C WAIVER RECIPIENTS

A. HCFA approved Section 1915c waiver services recipients (Specify each service as in the approved waiver.)			
A.1. PCA Personal Care Attendant	3,578		
A.2. Respite Care	2,544		
A.3 Substitute Family Care	67		
A.4. Residential Habilitation	1,339		
A.5. HAB/Supported Employment	428		
A.6. Prevocational Habilitation	574		
A.7. Day Habilitation	323		
A.8. Environmental Modifications	78		
A.9. Personal Emergency Response System	100		
A.10 Assistive Devices	34		
B.1. Total unduplicated Section 1915c waiver recipients served	4007		

ANNUAL SECTION 1915C WAIVER EXPENDITURES

A. Total HCFA approved section 1915c waiver services expenditures (Specify each service as in the approved waiver.)	$142,96,637	$	$
A.1. PCA Personal Care Attendant	$ 53,894,588	$	$
A.2. Respite Care	$ 29,985,816	$	$
A.3. Substitute Family Care	$ 249,839	$	$
A.4. Residential Habilitation	$ 44,482,878	$	$
A.5. HAB/Supported Employment	$ 2,360,917	$	$
A.6. Prevocational Habilitation	$ 2,742,350	$	$
A.7. Day Habilitation	$ 1,737,698		$
A.8. Environmental Modifications	$ 129,805	$	$
A.9. Personal Emergency Response System	$ 22,195		$

ANNUAL REPORT ON HOME AND COMMUNITY-BASED SERVICES WAIVERS

State Louisiana

Reporting Period July 1, 2001 June 31, 2002

Waiver Number 0200

Level/s of Care in Approved Waiver	ICF/MR		
A.10. Assistive Devices	$ 111,903	$	$
B.1. Average per capita Section 1915c waiver services expenditures (Actual Factor D value/s)	$ 35,674	$	$
III. Average per capita annual expenditures for all other Medicaid services to waiver recipients (Actual Factor D' values)	$ 5,287	$	$

IV. 1915c Waiver Cost-Neutrality Formula

$$D + D' \leq G + G'$$

$35,674 + $5,287 ≤ $60,872 + $4,341

$40,961 ≤ $65,213

To compute the cost neutrality formula, add the actual D (section II.B.1) plus the actual D' (section III) on the HCFA-372 (S). The sum of D plus D' must be less than or equal to the sum of the estimated G plus G' in the approved waiver request.

*If D + D' is greater that G + G', attach an explanation to the HCFA –372 (S) with documentation to support revision of G and/or G'.

V. OTHER REQUIRED DATA

A. 1. Total days of waiver coverage:	143,302		
2. Average length of stay of waiver coverage by level of care: (Total days of coverage divided by line B.1 of section I)	254		

B. Attach a lag report for the previous year of this waiver (including renewals and replacements) or an explanation of why there is no lag data.

C. Impact of the waiver on the health and welfare of the recipients. Complete items 2 through 7 only if you are submitting an initial report.

Assurances: (Please check)

☐ 1. Assurances were submitted with the initial report. (If you are submitting a lag report this item must be checked.) Lag report attached.

☐ 2. All provider standards and health and welfare safeguards have been met and corrective actions have been taken where appropriate

☐ 3. All providers of waiver services were properly trained, supervised, and certified and/or licensed, and corrective actions have been taken where appropriate.

2700.6 (cont.) STATE ORGANIZATION AND GENREAL ADMINISTRATION 0/95

Annual Report on Home and Community-Based Services Waivers

State Louisiana Page 03

Reporting Period July 1, 2001 – June 31, 2002

Waiver Number 0200

Documentation: (Please check and attach)

☐ 4. Attached is a brief description of the process for monitoring the safeguards and standards under the waiver. 5% Random sample supply on a semi-annual basis.

Findings of Monitoring: (Please check and attach documentation if appropriate).

☐ 5. No deficiencies were detached during the monitoring process; or

☐ 6. Deficiencies were detected. Attached is a summary of the signigifacnt areas where deficiencies were detected, (Note: Individual reports or assessment forms for waiver individuals and/or providers disclosing deficiencies and which document the summary are not necessary); and

☐ 7. Attached is an explanation of how these deficiencies have been, or are being corrected as well as an explanation of what steps have been taken to ensure the deficiencies do not recur.

Certification: I, do certify that the information shown on the Form HCFA 372 (S) is correct to the best of my knowledge and belief.

_____

Person: Ben Beardon

Phone Number: (225)342-3891

Cost Calculations for Center- Based Respite Rate Formula for Hourly Rate for Worker

Social Security	0.062
Medicare	0.0145
Federal Unemployment	0.008
State Unemployment	0.0194
Worker's Compensation	0.08
	0.1839

Hourly Personal Costs	
Average Hourly Wage	$6.00
Payroll Taxes/worker's comp.	1.10
Total hourly cost	$7.10

Hours per employee X Hours per week
40 hours per week X 52 weeks per year = 2,080 hours

Annual Employee cost = Hourly wage X hours per year
$7.10 X 2,080 = $14,768

None-billable hours:

Vacation	40
Sick	40
Training	60
PCP	40
Bereavement	16
Holidays	64
Total	260

Billable hours per employee	2080
Less non-billable hours	- 260
Total billable hours	1820

Cost per hour	
Total annual employee cost	$14,768
Divided by Billable hours	1820
Equals Cost Per Hour	$ 8.11

Other Cost

Travel	$ 0.56
Incidental	0.22 (outings with consumers)
Overhead	2.16
Total	$ 2.94

Total Hourly Rate $11.50

Cost Calculations for Per Diem for Substitute Family Care

Annual Payment to SFC Family	$14,235
Divided by	365 days =
For Per Diem per SFC family.	$ 39.00

Cost Calculations for Per Diem
for Residential Habilitation/Supervised Independent Living

Annual Salary of Team Manager (QMRP)		$26,000.00	
Plus			
Social Security	0.062		
Medicare	0.0145		
Federal Unemployment	0.008		
State Unemployment	0.0194		
Worker's Compensation	0.08		
	0.1839	$ 4,781.40	
Total Annual Employee Salary			$30,781.40

7 clients to be served by QMRP per day X365 days ÷ 7 clients = $12.05 per day

Cost per hour	
Total annual employee salary	$30,781.40
Divided by	365 days
Divided by 7 clients to be served	
Equals Salary Per Diem	$12.05 per day

Other Cost	$ 7.94

Overtime 5.23 hours per week X $10.66 per hour = $55.75 X 52 weeks = $2,899 ÷ 365 days=
Total cost of $19.99 per diem rounded to $20.00

Answers to Informal List of Questions Based on November 14, 2002 Telephone Call

NEW LOUISIANA MR/DD WAIVER APPLICATION

EXECUTIVE SUMMARY

Question 1.

How will the transition from the old waiver to the new waiver work? For participants? For providers? Will you review the plan of care as participants enter the new waiver?

Answer:

The transition from the old to the new waiver will be a six month process based on the individual's plan of care year. We plan to begin implementation in March, 2003 and finish in August, 2003, leaving September, 2003 as the "clean up" month so that we meet HIPAA requirements for October, 2003.

Participants will be "converted" at a rate of 2 months for CPOC renewal date for each month of implementation. For example in March, individuals with CPOCs ending in March and April will be "converted". In April, individuals with CPOCs ending in May and June will be converted, etc.

For providers we are currently updating and upgrading our Prior Authorization system to be HIPAA compliant and accountable. We have proposed local codes for services and have submitted a request to the fiscal intermediary to update the systems. Additionally, providers will be trained on the new waiver which would include services, billing and documentation. A provider enrollment training has been scheduled for early January, 2003.

Yes, the plan of care will be reviewed as participants enter the new waiver.

Question 2.

Item 11.t, Other Services: Is there a difference between the skilled nursing listed here and the one listed earlier? If not, take out skilled nursing services as it is already listed under i.

Answer:

Correction made, skilled nursing has been deleted from Item 11.t as it is the same service in "i".

Question 3.

Item 18: An effective date of January 1, 2003 is requested. How important is the effective date? The 90th day is 1/13/03.

Answer:

We had hoped that the January 1, 2003 date was a possibility to give us more time to educate system participants. We understand your 90 day timeline and therefore, the 1-13-02 is acceptable.

Question 4.

How does the state intend to ensure quality (health, safety, and welfare)? Explain the core functions of the state's quality management system (Prevention, Discovery, Remediation, and Improvement). What are the timeframes for these functions?

Answer:

Separate supporting documentation is attached.

Question 5.

Page 9: Should be home and community based waiver not "hoe"

Answer:

Corrected.

Question 6.

Page 9: Please have the director sign the signature page.

Answer:

Corrected.

APPENDIX B

Question 7.

Item e, Respite Care: Why exclude "for relief of those persons normally providing care"? Should the word "by" be inserted between the word "basis" and "a licensed" in the other service definition? Is transportation under respite different from state plan? Please indicate services are necessary to keep individuals from being institutionalized. What does "availability of community outings" mean?

Answer:

Suggested wording has been added and corrections have been made.

Yes, transportation for the respite services is different than transportation in the state plan.

Availability of community outings was important to our advocates, families and key stakeholders in order for the individual's receiving center-based respite services to continue to be connected to the community and still be able to participate in community events which may include school, and school functions and activities, and any other appointments as indicated on the CPOC. Information added in Appendix B.

Question 8.

Item g, Residential Habilitation: Where is Appendix G documentation that shows residential habilitation payments are not made to family members or for services for which payment is made by a source other than Medicaid?

Answer:

Correction made in Appendix G.

Question 9.

Item g, Supported Employment Services: What does the phrase "for whom competitive employment has not traditionally occurred" mean?

Answer:

Supported employment services are provided to individuals who are not served by Louisiana's Rehabilitation Services, need more intense, long term follow along and usually cannot be competitively employed as supports cannot be successfully faded. Information noted in Appendix B.

Question 10.

Item g, other service definition: Please expand on your definition of Facility Based Employment.

Answer:

Facility based employment services include related training designed to improve and/or maintain the individual's capacity to perform productive work, and function adaptively in the work environment. Services are provided one or more hours per day, for one or more days per week. This is included in Appendix B.

Question 11.

Item h, Environmental Accessibility Adaptations: Is the combined cap $8,000 per individual? Please mark the service definition. Move language in "other" up to the definition.

Answer:

Yes, the cap is per individual, document changed to reflect language. Language moved into definition from "other ".

Question 12.

Item i, Skilled nursing: Can this be reworded to look more like a service definition rather than a target group?

Answer:

Wording corrected to read as follows: "Skilled nursing services would include diabetes maintenance, oxygen therapy, ventilator tracheotomy care; hydration, nutrition, and/or medication via a gastronomy; severe musculoskeletal conditions/non-ambulatory status that require increased monitoring; dialysis; treatment for cancer requiring radiation/chemotherapy and end of life care not covered by hospice services. Services that may also include those relating to the use of life sustaining equipment necessary to sustain, monitor, treat an individual to ensure sufficient body function. Such medical equipment may include: ventilator; suction machine; pulse oximeters; apnea monitor; nebulizers."

Question 13.

Item k, Specialized Medical Equipment and Supplies: Typo - Please change specialized medical equipment and supplies in the sentence under other service definition to environmental accessibility adaptations. Would it be possible to separate the cap amount for the two services?

Answer:

This was an important point of the advocates, consumers, and families to have the maximum flexibility between a caps on the specialized medical equipment and supplies and environmental accessibility adaptations. However, we did separate the amount to $4,000 per individual per Item h. and Item k. Noted in the Appendix B.

Question 14.

Item m, PERS: Typo - Please fix typo in the last sentence which now reads "or where older or care givers"?

Answer:

Correction made.

Question 15.

Item s, Individualized Family Support: How will you reconcile with laws regarding authority to make medical decisions for patients? How will you avoid duplication of payment with respite? What are "direct services"? What are consumer directed services?

Answer:

The provider manual will address and specify procedures concerning who has the authority to make medical decisions, and other appropriate legal decision. It is not the intent that direct support staff should have this authority. Directions in the manual do not allow for receipt of two wavier services at the same time and system edits are being developed for billing.

Direct services are work that is performed "directly". This would include assistance with daily living skills, communication, and personal care.

Consumer directed services are defined in the attached supporting documentation.

Question 16.

Item s, Community Integration Development: How is Community Integration Development different from Day Habilitation? How will you prevent duplication of payment with day habilitation? Please reword so state does not exclude individuals younger than 18.

Answer:

Community Integration Development (CID) differs from day habilitation in the nature that CID is building community relationships, networks, and integration and day habilitation focuses on vocational based skills training. This information is included in Appendix B. The provider manual will state that CID and day habilitation cannot be provided at the same time and system edits are being developed for billing.

Question 17.

Item s, Professional Services: Are the professional services covered under the state plan? Does this need to be a bundle? What will the social worker do? What will the nutritionist or dietician do? How do you prevent duplication of payment with IDEA?

Answer:

No, professional services in this waiver are not covered under the state plan.

Professional services will not be bundled. Each professional service available will be individually identified under the broad category of professional services. Professional services consist of services only by a licensed psychologist, licensed social worker and licensed nurse.

The licensed social worker will perform functions governed by licensure. This could include one-to-one intervention, group intervention, initial assessments and treatment planning.

Nutritionist and dietician services have been eliminated.

Provider manual will state that the individuals must utilize EPSDT services; IDEA services other Medicaid state plan services prior to accessing HCBW services.

Question 18.

Item s, Professional Consultation: Is this a service for a specific individual? What does the state mean by "indirect"? How is this different from provider training? What are formal supports? Can this be built into professional services? Why are adult day care providers doing employment type services?

Answer:

Yes, professional consultation services are for any individual waiver recipient.

Indirect means "non-direct" intermittent services and would include assessments and evaluations that result in recommendations to the team or on behalf of the individuals daily activities.

This is different from provider training in the fact that a licensed professional is providing the consultation on behalf of the individual for the purpose of care planning and activities that can be performed by families, care givers and others who support the individual.

Formal supports are "paid supports" which would include individuals and providers.

Consultation services are just consultation, the professional services would be the actual ongoing therapeutic activities.

Adult day care is the licensure term in Louisiana for vocational providers.

Question 19.

Item s, One-time Transitional Expenses: Would you consider using the service definition crafted with CMS for your renewal?

Answer:

CMS language used.

Question 20

Item s, What are Transitional Professional Support Services (need more detail)?

Answer

Additional language included noting that these services are for crisis situations to stabilize the individual.

Question 21.

Item s, What are Shared Supports (need more detail)? Shared supports are usually reflected in the rate, not in the waiver application as a service definition. What happens if one of the people sharing supports no longer needs the supports or is absent for a day? Does this duplicate Substitute Family Care?

Answer:

Shared supports have been deleted as a separate services and included in the definition of individual and family support as discussed

This does not duplicate substitute family care.

Question 22.

Item s, What is a night companion (need more detail)? Is it offered when respite is provided? Who might get this service? Where is it provided? Why not necessary for the provider to be awake?

Answer:

Night companion has been removed as a separate service and put under individual and family support as discussed. Some waiver recipients need the availability of a night companion to be alert, available and in the same residence to assist with their needs and not necessarily awake.

Question 23.

Provider Qualifications: Where are the provider qualifications for Professional Consultation; One-time transitional services; and Shared Supports? Why do some items say N/A under certification and others say "NO"? Please list all cites for provider types, for example see professional services. What are DHH/BCSS standards for payment? Why mention home health under professional services? What

are consumer directed services under Individual and family support? What is a local occupational license? Can an individual nurse be a provider of skilled nursing?

Answer:

Information corrected in provider standards and cites referenced.

Overview of consumer directed services is contained in supporting documentation, Attachment 1.

Local or occupational licensures are applicable to certain professions, i.e. plumbers, carpenters and maybe required by certain parishes or cities in Louisiana.

Overview of BCSS Standards for Payment is included under supporting documentation, Attachment 2.

At this time an individual nurse may not be a provider of services.

APPENDIX D

Question 24.

D-2, Item a: Reevaluations of level of care must be every 12 months. Typo: delete "ask BCD about order".

Answer:

Corrected.

Question 25.

D-4, Where are the forms used to document a fair hearing? Where are descriptions required in D-4, 3.b and c?

Answer:

Fair hearing information and forms is included.

Question 26.

Do the people listed as performing the initial evaluations work together? How do you determine who performs the evaluation of the specific individual?

Answer:

Language clarification contained in Appendix D as follows "Individuals listed above may perform initial evaluations, may work together when necessary and may also work independently based on the determination made at the BCSS regional office level as determined through the Comprehensive Plan of Care Planning process."

APPENDIX E

Question 27.

Would the state consider approving 10% of the plans of care?

Answer:

No clarification needed, was clarified during 11-14-02 phone call as State approves 100% of the plans of care.

Question 28.

Plan of care: Is this a new plan of care? If not, how do you plan to transition? What are case

management agencies?

Answer:

Yes, this is a new plan of care. The transition of the plan of care will take place at the time the individual will be transitioned from the old waiver to the new waiver.

Case management agencies are the licensed enrolled providers that are responsible for developing the CPOC and offering freedom of choice for service providers and monitoring the ongoing needs of the recipient.

Question 29.

CPOC form should be in final version (the form states draft).

Answer:

Draft removed from document.

Question 30.

Should state person/individual instead of child.

Answer:

Correction made.

APPENDIX G

Question 31.

Please check math in Appendix G-2 and G-8.

Answer:

Math corrected and document revised.

Question 32.

Please break out bundled services for the cost-effectiveness evaluation.

Answer:

Cost shows psychologist, social worker and nursing services available.

Question 33.

Where do the numbers come from for Factor C? They are a lot less than what is listed in the old waiver.

Answer:

The numbers come from the FY 01-02 HCFA 372.

Question 34.

G-2: What are the units for Column C? Transition Start-up is not mentioned in Executive Summary or Appendix B? Information on Shared Supports; and Night Companion is missing. Should the average length stay be less for the first year, since a transition from the old waiver to the new waiver will be taking place?

Answer:

Appendix G, Executive Summary and Appendix B corrected.

Question 35.

G-3: Methods used to exclude payments for room and board should be completed for services furnished in residential settings (adult foster care, respite care, and possibly residential habilitation). Are you using SSI to pay for room and board? How are you determining the cost of room and board? What is the method used to factor out the cost of room and board?

Answer:

Documentation to state that per diem is for services only and does not include room and board has been incorporated.

Question 36.

This HCFA 372 form has not been approved. Only approved HCFA 372 forms can be used for appendix G. Please walk us through the HCFA Form 372 format you used and the numbers you chose. This form does not look like the standard HCFA Form 372.

Answer:

THE CORRECT AND APPROVED HCFA 372 IS ATTACHED.

Attachment I
Description of the Waiver Program
MRDD Waiver Consumer Direction Initiative

I. Purpose and Description of the Proposal

A. **Purpose:** For many citizens with developmental disabilities and their families, a new approach for increasing their quality of life while addressing financial considerations, will be offered as a Waiver Service Option in the MRDD Waiver. This new initiative will be implemented through a three-year phase-in process with two hundred fifty (250) participants. The empirical data collected through the first three years of the phase-in will be used to create a basis for systems changes in Louisiana=s Home and Community-based Waivers.

B. **Description:** Consumer Direction means a voluntary waiver participant or his/her appointed advocate has the right to choose what services and/or supports best fit their individual needs through the Person-Centered Planning process and where those services will be delivered. In addition, those participating will have the right to hire, fire, train and schedule workers whose are expected to provide the necessary direct services. (e.g., personal assistant, home-health skilled nurse, contractor, social worker, psychologist, broker, etc). A required component of this option will be the use of fiscal agents, approved to provide financial services and supports to participants who opt for consumer direction. Fiscal agents will be contracted to provide functions on the behalf of the participants such as: disbursement of public and private funds; monthly financial statements, audit reports, fiscal conduit, and generally be accountable for the individual=s budget. Case management (Supports Brokerage Activities) services are utilized for plan of care and individual=s budget development, advocacy, organizing the unique resources that the person needs and for ongoing evaluation of the supports and services.

II. Title of Program:

The MRDD Waiver with Consumer Direction Initiative

III. Support Brokerage Activities:

Case Management services will assist individuals, who choose Consumer Direction, in gaining access to all needed waiver services and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source. The case manager is responsible for documenting (writing) the plan of care (including the Individual Budget), submitting it to BCSS for approval, and distributing the approved plan to the fiscal agent, direct service provider, participant/representative and family (if appropriate) The case management agency convenes an interdisciplinary team to develop the plan of care and Individual Budget. The Individual=s Support Team may include professionals, providers, advocates, and the participant/family or friends as desired by the participant. Professionals may participate by report,

IV. Fiscal Agent Activities:

Assuming authority over an individual budget is a core element of consumer direction.

This means that the consumer may use, responsibly, an individual budget as a means to authorize and direct their providers of services and supports. The Bureau of Community Supports and Services (BCSS)/Department of Health and Hospitals (DHH) will contract with qualified vendors to serve as a Fiscal Agent for the consumer direction initiative through the issuance of a Request for Proposals (RFP) Process. The main components of the Fiscal Agent=s activities include:

1. Consultation with recipients on Fiscal Agent activities;

2. Timely processing and payment of invoices including tax and payroll functions consistent with Medicaid and state requirements;

3. Providing monthly expenditure reports to BCSS and the consumer;

4. Insuring all federal reporting, i.e. employee Social Security, Medicare, Worker=s Compensation and tax withholding required is completed timely;

5. Timely tax preparation for the consumer;

6. TTY Line;

7. Quality Assurance/Quality Improvement Plan including annual self-evaluation;

8. Generating reports to BCSS as requested;

9. Grievance Process-a method of receiving, responding to and tracking complaints from individuals/representatives within a reasonable time;

10. Toll-free phone line for recipients to access the Fiscal Agent Contractor to include a method for receiving, returning and tracking call from individuals/representatives and case managers during and after regular working hours (8 AM to 5 PM) with voice mail available after regular hours;

11. Utilization of an annual independent financial audit; and

12. Maintaining documentation of all activities including contacts with recipients.

The overall objective for the Fiscal Agent is to provide fiscal guidance and support to assist the consumer to achieve or maintain his/her independence and desired personal outcomes by honoring the principles of self-determination.

V. Compliance with Federal Requirements

Accountability for the use of public funds will be shared responsibility of DHH, the single State Medicaid Agency: BCSS, Contracted Case Management, Contracted Fiscal Agent and the Consumer. BCSS will review and approve the Individual=s Budget prior to authorization of the services. As the plan of care is the fundamental tool by which the State will ensure the health, safety and welfare of the individual/participant, the Comprehensive Plan of Care will be updated and approved at a minimum of annually (12 months) by BCSS and revised as needed for changes in the individual=s service and support needs. Revision to the CPOC must be submitted and approved by BCSS before implementation of payments by the Fiscal Agent.

The State provides the following assurances to CMS:

A. Health & Welfare – Necessary safeguards will be taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver;

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements will be met on the date that the services are furnished;

3. The DHH maintains Medicaid Provider agreements for all providers participating in HCB Waiver Services.

B. Financial Accountability – The State will maintain the financial integrity of the HCBS Waiver program. The State will assure financial accountability for funds expended for Home and Community – Based Services, provide for an independent audit of its HCB waiver program, and will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

BCSS will assure compliance with Federal Regulations through the same mechanisms as with all other waiver service options as described in the MRDD Waiver Document. Specifically:

1. An individual=s written plan of care will be developed by a qualified case manager and will describe the medical and social services to be furnished, their frequency, and the type of provider who will furnish each service. The Plan of care will be subject to the approval of BCSS and updated and approved at a minimum of every 12 months. FFP will only be requested for services rendered after the development/approval (by BCSS) and only for services in the approved plan of care.

2. Waiver participants will meet the ICF/MR institutional level of care and services will not be rendered to waiver participants who are inpatients of a hospital, Nursing Home or ICF/MR.

3. BCSS provides assurances as described in the **MRDD Waiver Document under # 16, letters a. through i.**

VI. Individual Budgets

Individual Budgets are determined as a function of the comprehensive care planning by the Individual=s Support Team. The Individuals= Budget will include an amount of dollars over which the participant/representative or his/her family (as appropriate) exercises decision-making authority concerning the selection of services, service providers, and the amount of services. The Individual=s budget is reviewed as part of the Comprehensive Plan of Care (CPOC) by the Regional BCSS staff. The Individual=s CPOC and Individual Budget are updated and reviewed by BCSS annually.

Fiscal responsibility and the wise use of public funds shall guide the consumer and case manager in preparation of the Individual Budget. Fiscal responsibility in the use of waiver services means providing the appropriate mix of paid/non-paid services and supports to assist the individual in achieving his/her personally defined goals. Accountability for the use of public funds will be shared

responsibility of DHH, the single State Medicaid Agency: BCSS, Contracted Case Management, Contracted Fiscal Agent and the Consumer. BCSS will review and approve of the Individual=s Budget prior to authorization of the services. As the plan of care is the fundamental tool by which the State will ensure the health, safety and welfare of the individual/participant, the Comprehensive Plan of Care will be updated and approved annually (every 12 months) by BCSS and revised as needed for changes in the individual=s service and support needs. Revision to the CPOC must be submitted and approved by BCSS before implementation of payments by the Fiscal Agent.

Training will be provided by the contracted Fiscal Agent for the Participant/Representative or Family Member (as appropriate for a child) and Case Manager in Budget Preparation and Fiscal Management of the Individual Budget.

VII. Support Staff

~~The participant shall be able to access alternative methods to choose, control and direct personnel necessary to provide direct support, including,~~

~~1. Acting as employer of record of direct support personnel (i.e, hiring, training and firing of personnel).~~

~~2. Access to a provider that can serve as employer of record for the personnel selected by the consumer. The fiscal agent implements an agreement with a provider agency to provide the direct support staff.~~

The participant=s direct support may be provided by an employee of an enrolled service provider or, may be a qualified individual approved by BCSS, who is not employed or subcontracted by an enrolled service provider. The Fiscal Agent will provide the necessary criminal background checks, employment reporting and withholding, and all payroll functions for the Individual Provider. (i.e., one not employed by an enrolled service provider).

Training for direct care will be provided specific to the individual=s waiver and service needs. It will be the responsibility of the case manager to ensure the consumer has a list of training sources where training may be purchased for the Individual Provider (not employed by a Service Provider). BCSS retains the right to determine the level of training and the qualifications needed by the Individual Provider as a component of quality assurance and assuring the safety and welfare of the waiver participant. This determination will be made by the BCSS staff reviewing and approving the individual=s CPOC.

VIII. Oversight

Direct oversight of the Individual=s Budget is the responsibility of the Case Manager in coordination and with the cooperation of the contracted Fiscal Agent. The Case Manager will receive a monthly report of the individual=s budget, invoices paid and balance of funds. This report allows the case manager to evaluate the continuing financial needs of the individual.

Consumer Direction participants will be monitored either thru specialized monitoring or among the annual 5% cases monitored by BCSS Quality Management Section. The monitoring process includes assuring that services were rendered as per the individual=s approved care plan. Any deficient practices identified through the monitoring process will be addressed with a letter of deficiency citation and a request of a plan of correction from the agency. This process will

include monitoring the performance of the direct service provider, the case management agency and contracted fiscal agent.

BCSS will monitor the fiscal impact of the initiative as part of the annual performance indicators for program assessment and strategic planning. In addition, the fiscal agent will be monitored for compliance with contract provisions through annual review and the mandated annual self-evaluation and Quality Assurance Plan Report.

IX. Consumer Satisfaction

Consumer satisfaction with the Consumer Direction Initiative will be assessed throughout the implementation period, especially the first three years of phase-in as follows:

A. Selection of participants: From the pool of people who receive support from Louisiana=s MR/DD home and community-based waiver, a group of 250 individuals who choose consumer direction and live in Regions 1,2, and 9, whose plan of cares is next to be developed will be identified as potential participants by the BCSS. Each participant will have a waiver "slot" and some may also have other funding sources such as SSI, vocational rehabilitation, personal earning, etc.

B. Selection Process:

1. A total of 250 participants will be identified from the MRDD Waiver in the following Regions: 1, 2,and 9 by BCSS.

2. The first six months of the first year, 50 individuals whose CPOC is next from the list of potential participants in the Waiver will be offered the opportunity to choose consumer direction for Individual and Family Support Services only.

3. The second six months, 50 MRDD Recipients from the list of potential participants will be selected for consumer direction for Individual and Family Supports Services only.

4. The second year, 75 Recipients will be selected and all waiver services may be consumer directed, for year 1 participants and year 2 participants.

5. The third year, the remaining 75 of the 250 potential participants will be offered consumer direction for all waiver services.

6. The fourth year and thereafter, it is expected that the consumer direction service option will become available to all waiver recipients.

C. Program Evaluation Methods

1. Using a natural comparison group, the first year participant=s out-comes will be compared to those MRDD Waiver Recipients not participating in the Consumer Direction Option, but who are receiving traditional waiver services.

2. The second year, this option will have up to 175 participants and a comparison group of 175 still receiving tradition waiver services.

3. The third year the remaining 75 participants will participate in consumer direction and

will allow for a longitudinal study and analysis.

4. Slice of time analysis will also be performed for the 75 third year participants, and the comparison group approach will be used to refine the process and service delivery system.

5. Based on program evaluation, necessary changes in process will be made to insure HCB waiver compliance and recipient satisfaction.

X. Participant Protections:

A. Annual CPOC Review and Approval:

BCSS will review all current medical, social and psychological assessments in relation to determination of level of care, medical certification and annual CPOC approval. These assessments form the basis for evaluating the CPOC=s for appropriateness to meet the participant=s service and support needs.

B. Initial Pre-certification Home Visit:

BCSS Regional staff conducts a pre-certification home visit, which includes interviews with participant/authorized representative and environmental safety assessments. BCSS staff will make recommendations for any identified safety hazards identified or other concerns not consistent with the CPOC.

C. Annual 5% Monitoring Home Visits:

As part of the 5% monitoring activities, BCSS staff make home visits to the randomly selected participant=s home. During the home visit, the participant and the participant=s direct care staff are interviewed relative to satisfaction, service/supports needs and the environment is assessed for safety hazards. BCSS staff assures that the participant=s personal emergency plan is available in the home. In addition, the participant is given the Toll Free Help Line number for BCSS again.

D. Complaint/Help Line: A central point to call in complaints and/or incidents involving health and safety:

1. BCSS maintains a toll free telephone line for participants to call for assistance or to lodge a complaint about any of their waiver services. This phone number is given to the participant upon the initial intake contact by the case manager and later during the pre-certification home visit by BCSS staff. The case manager must frequently assure the participant has the toll free number available. During the annual 5% monitoring by BCSS, the home visit is BCSS=s opportunity for assuring that the participant has the toll free number and if not, the case manager may be cited for deficient practice. The toll free number is provided at each home visit by the case manager and BCSS staff.

2. Complaint Investigations are done for every complaint made and the resolution is determined and communicated to the appropriate entities. Complaints are tracked for trend and pattern analysis and to identify specific deficient practices by service providers and case managers.

E. Critical Incident Reporting: Critical Incidents are those which allege the individual is abused, neglected, exploited, or extorted, has suffered serious harm or physical injury (explained or unexplained) which if, untreated, may result in permanent physical damage or death

1. Any person having knowledge of the incident must report the incident via the toll free help line.

2. Critical incidents will be processed through external and internal procedures.

3. Critical incidents may be investigated by the following: direct service provider, the case manager, and the BCSS regional staff. The investigation will be conducted following the Critical Incident Protocol/Procedures provided to all Service Providers and Case Management Agencies.

4. Critical Incidents are received on the Toll Free Help Line and are sent to the appropriate BCSS Regional Office Manager for assignment to regional staff for the investigation and reporting of findings to the Critical Incident/Complaint Line Manager.

5. Critical Incident Final reports are reviewed by the Critical Incident/Complaint Line Manager to determine if resolution has been made and if there is a need to write a letter of citation for any identified deficient practices by service provider.

6. The Quality Assurance/Quality Enhancement Committee reviews the Critical Incident Log to identify trends and patterns and plan for corrective actions that may be required.

Emergency Back up/Natural Disasters & Other Emergencies

The CPOC must include plans for emergency backup as well as plans for natural disasters and other emergencies based on the individual's specific needs and availability of informal support systems.

Participants must have a current copy of the CPOC and service provider plans.

Monitoring for continued appropriateness of the plan is completed during the Case Manager's quarterly visits and BCSS monitoring visits.

4. IN ADDITION TO THE PARTICIPANT'S INDIVIDUALIZED PLAN IN THE CPOC, DIRECT SERVICE PROVIDERS MUST MAINTAIN EMERGENCY BACK-UP SYSTEMS.

5. DHH and BCSS are both first alert agencies which participates in emergency preparedness activities for the state of Louisiana for Shelters for Special Needs Citizens. Through an automated data base BCSS Regional Offices & Case Management agencies have call lists and follow up plans for individuals receiving HCB Waiver Services.

CRIMINAL BACKGROUND CHECKS

1. Criminal Background checks are required and available either through the Fiscal Agent Services or the Direct Service Provider.
2. Monitoring for compliance with this state law is insured through licensing and waiver monitoring visits.

State of Louisiana
Bureau of Community Supports and Services
December 2, 2002

I. PARTICIPANT ACCESS

A. User-friendly processes:

Dissemination of information via:

1. Toll free hot line to respond to inquiries about BCSS.
2. Collaboration with advocacy & consumer groups.
3. Collaboration with the developmental disabilities agency (OCDD).
4. Web-site.
5. Ongoing presentations to all stakeholders & service organizations.

B. Streamlined Processes

1. Access processes continuously evaluated for user-friendly access and response to questions/complaints.
2. Coordination between Help Line, Regional Services Offices and Case Management and Direct Service Providers for problem solving.
3. Coordination between Developmental Disabilities Agency and BCSS for technical assistance and service access.

C. Process Review of the Intake System.

1. Case Management Agencies are monitored for time lines and cited for failures to meet required time lines.
2. Contract compliance is monitored by BCSS and includes meeting time lines for intake and assessments.

D. Services are promptly initiated

1. Specified Time Lines are monitored through payment systems and reports.
2. Case Management and other Providers: Required QA/QI plan and self-evaluation annually.
3. Semi-annual Monitoring of randomly selected 5% of wavier recipients.
4. Deficiency citations for those providers out of compliance with corrective action plans required.

II. Participant Safeguards

A. Case Management Agency Requirements

1. Must meet stringent criteria for selection.
2. Must maintain qualified case managers and supervisors.
3. Case Load limitations part of criteria for participation.

B. Risk and safety planning

1. Comprehensive Care Plans includes participant & environmental assessments (pre-certification home visits).
2. Critical Incident Reporting to BCSS includes investigation and resolution.
3. Critical Incident tracking for trends & patterns by QA/QE system.
4. High Risk Participants are identified for more frequent monitoring. (Includes those with Critical Incidents or fragile medical conditions).
5. Immediate Jeopardy Situations identified as a result of investigations or monitoring activities and actions are taken to ensure safety.
6. Abuse/Neglect cases are coordinated with the appropriate Protective Service Agency.

C. Natural Disaster/other emergencies

1. Comprehensive Care Plans must include Emergency and disaster planning before approval by BCSS. These Comprehensive Care Plans must include Emergency back up plans to address Direct Support Staff absences.
2. Participants must have a copy of the plan in their homes; identified through Case Management Review and BCSS 5% monitoring activities.

D. Medication Management:

1. Medication errors must be reported to BCSS through Critical Incident Reporting.
2. Medication management is monitored through the assessments and service planning in the Comprehensive Plan of Care (CPOC), during the semi-annual 5% monitoring by BCSS and the Case Manager's quarterly monitoring.

E. Housing/personal security

1. BCSS Pre-certification visit to assess the appropriateness of the CPOC, satisfaction of the participant and the home for environmental hazards.
2. Home visits during 5% monitoring.
3. Satisfaction Interviews with participant & families.
4. Case Manager's Quarterly face-to-face visit/monitoring.

III. Provider Capacity & Capabilities

A. Enrollment/Licensure

1. Case Management Licensing thru BCSS
2. Service Provider Pre-enrollment Orientation, re-enrollment with orientation on Specific Provider Standards required before enrolling as New MR/DD Waiver Provider.

B. Training/Technical Assistance

1. Provider Training by BCSS and other authorized Trainers.
2. Quarterly Direct Service Provider Meetings with Regional BCSS Staff.
3. Technical Assistance by BCSS for Corrective Action Planning.
4. Quarterly Case Management Agency Meetings with State Agency Staff.

C. Performance Monitoring

1. 5 % monitoring of Waiver Participants and those who provide direct services and case management by BCSS.
2. Case Management Quarterly monitoring of direct service providers.
3. High Risk Monitoring of waiver participants and those who provide direct services and case management.
4. Critical Incident Reviews, corrective actions and follow-along as applicable.

IV. Participant Rights & Responsibilities

A. During Eligibility Process/Intake

1. Written Rights and Responsibilities disclosure regarding Medicaid and HCB Waiver Services.
2. Written Rights and Responsibilities disclosure during initial Case Management Meeting & Assessment.
3. Written Rights and Responsibilities disclosure upon annual CPOC Planning.

B. Monitored via:

1. Pre-certification Home Visit by BCSS.
2. 5% Semi-annual monitoring home visit with interviews.
3. Consumer Satisfaction surveys by QA/QE Committee.

C. Toll Free Help Line

1. Toll Free Help Line available for questions and support.

D. Freedom of Choice

1. Participants are informed of their freedom to choose service providers and case managers.

E. Due Process Rights are provided as needed through letters to the participant upon eligibility determinations

1. Education and Communication on due process provided to participants by Case Managers through the CPOC planning process.

V. Person Centered Planning and Service Delivery

A. Person Centered Planning

1. Training Provided by BCSS.
2. Personal Outcomes Training for case managers and direct service providers provided by BCSS.

B. Monitoring

1. 5% monitoring to review Person Centered Approaches completed through home visits and participant interviews.
2. Quarterly Case Manager's face to face visit/interview addresses personal outcomes.
3. Consumer Satisfaction Surveys BCSS QA/QE Program assesses satisfaction with personal outcomes.

C. Program Planning

1. Stake holder forums and work groups used for feedback and for program design.
2. DHH MR/DD Family/Stakeholder work groups meet monthly.
3. Collaboration with developmental disabilities agency ongoing with weekly meetings and special activities.

D. Individual Support Teams

1. Support Teams used for planning and personal outcome assessments that are responsive to participant's changing needs.
2. Circles of Support developed for recipients.

VI. System Performance

A. Annual Program Evaluation and Planning

1. Ongoing Strategic Planning activities.

B. BCSS Performance Indicators

1. Annual review of BCSS performance indicators.

C. DHH Quality Management Customer Satisfaction Program

1. Satisfaction reviews completed annually.

D. Ongoing monitoring of service provision via BCSS data collection systems

1. Quality Assurance/Quality Enhancement Program uses data based decision-making as well as individualized reviews.

E. Quality Assurance/Quality Enhancement Program

1. Service Peer Review Panel meets weekly.
2. Customer Satisfaction Surveys annually.
3. Trends & Patterns Analysis reviewed monthly.

F. Feedback from Stakeholders during forums, work groups, and planned feedback activities.

1. Quality Assurance/Quality Enhancement Program uses feedback from diverse groups for performance planning recommendations.

G. Development of a Citizen's Monitoring Program for QA/QI Participant Outcomes & Satisfaction for New MR/DD Waiver Activities.

1. Process in development with stakeholder groups.

VII. Participant Outcomes & Satisfaction

A. Personal Outcomes Assessments

1. Completed annually by case manager
2. Completed by BCSS 5% monitoring annually.

B. Customer Satisfaction Surveys

1. Completed annually by case manager, BCSS monitoring
2. Completed by BCSS 5% monitoring annually.
3. Completed through QA/QI Program annaully.

C. Toll Free Help/Complaint Line

1. Trends and Patterns Analysis of complaints and assistance calls completed to evaluate needs at least quarterly.

D. Mandatory Grievance Policy and Procedures for all providers

1. Utilized as needed.

E. Cultural diversity responsibilities for service providers.

1. Participants encouraged to request specialized services consistent with Cultural Needs

through the planning process.

F. Forums for self-advocates and stakeholders in Program Planning.

1. On-going system feedback obtained from self advocates and other key stakeholders.

G. Consumer Direction activities: formal and informal.

1. Currently, Louisiana encourages informal use of consumer direction principles by waiver participants as follows:
    a. To take an active part in their HCB Waiver planning process and
    b. Supports the use of consumer directed opportunities such as making recommendations to providers in the selection and discharge of direct support workers and the evaluation of these workers.
2. Participants are offered freedom to choose case managers and direct service providers.
3. The new MR/DD Waiver will offer formal consumer direction opportunities with the use of a fiscal agent.
    a. QA/QI systems are being planned to using the current QA/QI system framework to evaluate access, provider capacity, rights and responsibilities, person centered principles, safeguards, performance, outcomes and satisfaction with this new option.

H. Personal Life Quality Assessment for personal outcomes by external reviewers.

1. Process in development with stakeholder groups for citizens monitoring to increase availability for system feedback from participants.

ANSWERS TO ISSUES DISCUSSED
In December 16, 2002 Telephone Conference Call

APPENDIX B

Question 1.

Item s, Individualized Family Support: Shared supports: What if only one individual in a shared support setting was available because of sickness, moving etc? Let's discuss the difference from respite.

Answer:

If only one individual was available, then billing will be adjusted to reflect level of services provided. (i.e. that it was individual and family support and not shared support.) The CPOC and Prior Authorization would be adjusted.

Individual and family support cannot happen in a respite setting. Respite is only provided in a center based setting, which is licensed as a respite care center. These additions are reflected in the service definitions under Appendix B both under Respite and Individual and Family Support.

Question 2.

Item s, Community Integration Development: Add – as part of transition to the community?

Answer:

Language has been added in the Appendix B to include those individuals transitioning from ICFs/MR.

Question 3.

Item s, Professional Services: Let's discuss the bundle.

Answer:

The professional services have been separated out in Appendix G for calculations.

Question 4.

Item s, Professional Consultation: Please specify in the definition that this service is for a specific individual.

Answer:

In Appendix B this information was added.

Question 5.

Item s, Transitional Professional Support Services: Need more detail.

Answer:

Additional language added in Appendix B.

Question 6.

Provider Qualifications: Where are the provider qualifications for One-time transitional services? PERS: mark N/A under license? What are provider qualifications for one-time transitional services?

Answer:

The one-time transitional services will be provided by the BCSS's sister agency, The Office for Citizen's with Developmental Disabilities (OCDD), which is the program office for people with Mental Retardation and Developmental Disabilities in Louisiana. This has been incorporated in Appendix B2 Provider graph. PER's has been marked N/A under license.

Question 7.

How will you ensure the needs of people after they have reached the cost cap on those services with a cost cap?

Answer:

Quality Assurance Systems are in place that will allow for proactive approaches to insure communication and education with recipients and authorized representative regarding service utilization. Should an individual's needs change, a meeting of the individual's circle of support will address natural and generic resources, including the utilization of state funds. The following language has been added to both the professional services and professional consultation definitions in Appendix B: ***"If the individual reaches the cap before the expiration of the plan of care year and the individual's health and welfare are at risk, on a case by case basis and based on additional documented need for services, additional services can be prior authorized for approval."***

APPENDIX D

Question 8.

Where are the forms used to document a fair hearing? Where are descriptions required in D-4, 3.b and c? Please point them out.

Answer:

The form 18W is the form that documents the fair hearing and it will be included as Attachment II to Appendix D to this revision being sent. The descriptions regarding D-4, 3.b. and c. are included in this revision as Attachment I, Appendix D to this revision being sent.

APPENDIX E

Question 9.
CPOC form should be in the final version (the form states draft)
Answer:

The final CPOC has been attached to this document and labeled as CPOC.

APPENDIX G
Question 10.
Please check math in Appendix G-2 and G-8. (Especially year 1)
Answer:

Math errors corrected.

Question 11.

Need units for Appendix G-2 environmental accessibility adaptations and specialized medical equipment and supplies.

Answer:

Units added.

Question 12.

Should the average length of stay be less for the first year?

Answer:

Length of stay reduced for first year.

Question 13.

Appendix G-3 needs to be completed.

Answer:

Appendix G-3 completed.

SELF-DIRECTION ISSUES (SOME OF THESE QUESTIONS ARE PARTIALLY ANSWERED IN YOUR WRITE UP, WE JUST NEED MORE DETAIL) SUPPORTS BROKERAGE

Question 14:

Describe the responsible entity including relationships with the Medicaid Agency and list contracts/subcontracts arranged or to be arranged.

Answer:

Contracted Case Management Agencies, who currently function within the Medicaid System as agents of the Bureau, will assist individuals choosing the Consumer Directed Service Option, in supports brokerage, gaining access to all needed waiver services and other State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source. The Individual freely chooses the case management agency through Freedom of Choice Procedures and is linked to the case management agency for a six (6) month period, with a provision for allowing the Individual to make a change within the six month period for "Good Cause". The Individual may choose a different Case Management Agency at the end of each six-month period without explanation.

The case manager is responsible for working with the individual in developing a circle of support, meeting with the individual and their circle of support to develop a person-centered plan, documentation of (writing) the plan of care (including the Individual Budget), submitting the plan to BCSS for approval, and distributing the approved plan to the fiscal agent, direct service provider, participant/representative and family (if appropriate). The case manager facilitates the Individual's Support Team, made up of professionals, service/support providers and the Individual's family or friends as desired or invited by the participant. (Professionals, such as the primary care physician, psychiatrist, psychologist or therapist, may participate by report in lieu of attending). Case managers also provide oversight of the service provision. On a quarterly basis, the case manager has the responsibility to monitor the service provision to be sure the services provided are those which are included in the Individual's approved Comprehensive Plan of Care (CPOC) and that the current CPOC continues to meet the support needs of the Individual receiving home and community-based waiver services.

Case Managers are also responsible for evaluating customer satisfaction with their services and supports. Case management agencies must report to BCSS on their activities supporting Individuals through the CMIS Data System. This communication, along with on site monitoring by BCSS, with allows BCSS to assure that case management agencies are functioning within the requirements of their contract and the Case Management Service Manual.

Question 15

Who provides the activities?

Answer:

The case manager is responsible for initiating and facilitating the Individual Support Team Meeting; The Individual's Support Team may include professionals, providers, advocates, and the participant/family or friends as desired/invited by the participant. The end product of the Individual Support Team Meeting is the Individual's Comprehensive Plan of Care, which must be person-centered and support personal outcomes.

The case manager is responsible for documenting interventions identified during the Individual Support Team Meeting into the comprehensive person-centered plan of care, (which includes the Individual Budget), submitting it to BCSS for approval and prior authorization, and distributing the approved plan to the fiscal agent, direct service providers, Individual/Representative and family (if appropriate).

The case manager is also responsible for locating services, accessing services and assuring services are provided as per the Individual's approved CPOC.

Include title and qualifications.

Answer:

Case Managers: Our current contracts with case management agencies state that case managers must have a Bachelors Degree and one (1) year experience in the field of Human Services work related to individuals with disabilities or a related field. The Case Manager's caseload cannot exceed 35 waiver participants, but is less in some situations.

Case management is not listed as a service in the waiver. How does self-directed case management differ from current case management?

Answer:

Case Management is not a waiver service. There is no difference in the self-directed case management activities and the current MRDD Waiver Case Management. Case Managers will be trained in consumer direction policy and procedures so that regardless of the options chosen by the recipient, the Case Manager will be able to provide or secure assistance. The case management services are offered as Targeted Case Management through the State Plan.

QUESTION 16

Who will provide oversight/monitoring? Include how and frequency.

Answer:

The Individual's Case Manager provides services oversight on a quarterly basis. The case manager is responsible to report any failures by a service provider to provide the services approved in the Individual's CPOC. In addition, the case manager is expected to communicate with the Fiscal Agent, as needed to ensure the Budget and CPOC continue to meet the consumer's service/support needs.

Budget oversight is provided by the contracted Fiscal Agent, as required through their contract with BCSS. Activities include providing BCSS and the Consumer with monthly expenditure reports.

BCSS will provide oversight of the case management agency, the direct care providers and the Fiscal Agent by way of the Quality Management Section's semi-annual monitoring activities and through Consumer Satisfaction Surveys conducted by the Life Perspectives Team (made up of self-advocates, advocates and family members). QA/QI activities are also required of the case management agencies The BCSS Case Management Program Manager also monitors Case Management Agency activities monthly, through CMIS Reports.

Question 17

Describe the reimbursement process. Are these activities claimed as a waiver service or as an administrative cost?

Answer:

The case management services are offered as Targeted Case Management through the State Plan.

FISCAL/EMPLOYER AGENT ACTIVITIES

Question 18

Describe the responsible entity including relationship with the Medicaid Agency and include contracts/subcontracts to be arranged.

Answer:

The Bureau will contract with a Fiscal Agent to provide financial support services. The agent will be selected through the State of Louisiana Request for Proposal (RFP) process. The objective of the Fiscal Agent Contract is to offer an option for payment of waiver services and to provide fiscal guidance and support to assist the consumer to achieve or maintain his/her independence by honoring the principles of self-determination (freedom, responsibility and support). The fiscal agent functions to process and pay invoices for services, selected by the individual and designated in their Individual Budget, which were rendered to the participant. The Agent will serve three (3) geographic regions initially. The Agent must meet qualifications outlined in the RFP, (Staff—CPA/ degree in humanities /social sciences or related field and experience working with individuals with chronic conditions/elderly issues and/or disabilities or a related field).

The Fiscal Agent will not serve more than 250 individuals. The Agent's staff will meet with the individual and the case manager to review participant's service needs and to discuss the back-up plan. The case manager and the individual will discuss the back-up plan with the agent, which may include informal-non-paid caregivers or an agency (respite center, etc) from which hours may be purchased. The Agent will inform the Individual and/or their representative regarding the fiscal activities and determine the level of fiscal support required. The Agent will assure that a written work agreement is executed between the individual and or their representative and each of their employees. This agreement will detail the tasks, days, and number hours of services agreed upon. All parties will be given a copy of the agreement for their records. The agent should also discuss measures for addressing needs should there be an unexpected shortage of funds—(needs exceed original budgeted needs). The agent will generate monthly

reports that will allow Individuals and/ or families to keep tract of expenditures, etc.

The main components of the Fiscal Agent's activities include:

1. Consultation with recipients on Fiscal Agent activities;
2. Timely processing and payment of invoices including tax and payroll functions consistent with Medicaid and state requirements;
3. Providing monthly expenditure reports to BCSS and the consumer;
4. Insuring all federal reporting, i.e. employee Social Security, Medicare, Worker's Compensation and tax withholding required is completed timely;
5. Timely preparation of information required for tax purposes (W-2) for the consumer's employees.
6. Maintenance of a TTY Line;
7. Quality Assurance/Quality Improvement Plan including an annual external audit and self- evaluation;
8. Generating reports to BCSS as requested;
9. Grievance Process-a method of receiving, responding to and tracking complaints from individuals/representatives within a reasonable time;
10. Toll-free phone line for recipients to access the Fiscal Agent Contractor to include a method for receiving, returning and tracking call from individuals/representatives and case managers during and after regular working hours (8 AM to 5 PM) with voice mail available after regular hours;
11. Completion of an annual independent financial audit; and
12. Maintain documentation of all activities including contacts with recipients.

The overall objective for the Fiscal Agent is to provide fiscal guidance and support to assist the consumer to achieve or maintain his/her independence and desired personal outcomes by honoring the principles of self-determination (freedom, authority, responsibility and support

QUESTION 19

Who will provide oversight/monitoring? Include how and frequency.

Answer:

BCSS oversight of the Fiscal Agent occurs through review of the required monthly reports from the Case Manager (CMIS Report); the Fiscal Agent's Monthly Report; through the semi-annual Consumer Satisfaction Surveys, conducted by the Life Perspectives Team and the BCSS Quality Management Section's (semi-annual) Monitoring Activities. In addition, BCSS and the Louisiana Bureau of Health Care Financing (Louisiana Medicaid) conduct an annual joint audit of all waiver programs.

Reports generated by the Fiscal Audit:

1. The fiscal agent will monitor the waiver expenditures to assure that the individual is receiving the services that are required by the CPOC.
2. There will be at least one contact with the waiver participant monthly, maybe more, and all contacts must be documented in the individual's file. If any changes or issues are noted, the agent will contact the case manager for resolution. The case manager will assess the situation and determine if plan is still appropriate or if plan requires a change.
3. If budgetary issues are noted via the Fiscal Agent's monthly report, BCSS will follow-up with the Fiscal Agent, Case Manager and the Individual to determine if the plan/budget is still appropriate or if a revision to the CPOC is necessary.
4. Frequent communication between the Case Manager and the Fiscal Agent will be encouraged to ensure the Individual's CPOC and the Individual's Budget continue to meet the Individual's service/support needs.

Question 20.

Describe the reimbursement process. Are these activities claimed as a waiver service or as an administrative cost?

Answer:

The Fiscal Agent will be reimbursed at an established rate and process as determined through Agent's Contract with the Bureau.

Reimbursement by the Fiscal Agent for Service Providers will occur as follows: DHH/BCSS/Fiscal Intermediary (UNISYS) will send a check to the Fiscal Agent each month to cover the cost of the authorized services. The consumer and their case manager will arrange for the services to be provided and invoices will be sent to the Fiscal Agent for payment. The Fiscal Agent will process the invoices monthly, make necessary withholding tax/payroll functions and ensure prompt payment to the service providers and reimbursements for services rendered.

Question 21

Whose taxes does the Fiscal/Employer Agent complete?

Answer:

The agent does not complete taxes but prepares the forms, such as the W-2, W-9, and etc., for the individual's employees. The Fiscal Agent does withhold and pays payroll taxes for IRS for the direct service professional employed through an agency.

COMPLIANCE WITH FEDERAL REQUIREMENTS

~~Question 22.~~

~~**Who holds the Medicaid Provider Agreement(s)**~~

~~Answer:~~

~~The Louisiana Medicaid office holds this provider agreement.~~

Question 23.

Explain the flow of funding from the Medicaid Agency to each provider of services.

Answer:

Please see faxed flow charts.

Common-law Employer (Employer of Record)

Question 24.

Who is responsible for payroll tasks?

Answer:

The fiscal agent is responsible for payroll taxes.

~~Question 25.~~

~~**Who is considered the common-law employer?**~~

~~**Answer:**~~

~~The Fiscal Agent.~~

PLAN OF CARE

Question 26.

What are the policy and procedures that define and guide the family or person-centered planning process and assure that families are integrally involved in the plan development and that the plan of care reflects their preferences, choices, and desired outcomes?

Answer:

The principles of consumer direction are the principles that guide all activities of this waiver.

Consumer Direction, for those choosing to utilize the services of the Fiscal Agent, is defined as a voluntary waiver and participants or his/her appointed advocate has the right to choose what services and/or supports best fit their individual needs through the Person-Centered Planning process and where those services will be delivered. In addition, those participating will have the right to hire, fire, train and schedule workers who are expected to provide the necessary direct services, (e.g., personal assistant, home-health skilled nurse, contractor,

social worker, psychologist, broker, etc. Case management services are utilized for the supports brokerage process in the for plan of care process and individual=s budget development, advocacy, organizing the unique resources that the person needs and for ongoing evaluation of the supports and services.

Question 27**.**

Provide a description of the process and parameters within which families or individuals have flexibility to utilize resources identified within the plan of care and the individual budget that do not necessitate a formal revision to the plan of care.

Answer:

The Individual Budgets reflect the principles of self-determination when the budget is actually controlled by the person and his or her support circle. The budget must be individually created by the person with the disability and his or circle of support within the funding allotted to the individual for support and services. The budget must be needs based and reflect the individual needs and desires of the person with disabilities as determined in the person-centered planning. Budgets must be flexible, within the approved amount and CPOC, to move dollars from one line item to another or create new line items as needed to maintain the individuals support and provide for personal crisis situations.

In addition, what is the State's infrastructure to support families or individuals in directing and managing their plan of care?

Answer:

The Prior Authorization process will allow authorization of services for a quarter span of time, giving families flexibility with funding and utilization of services. In addition, the CPOC and its revision process allows for the same flexibility.

Question 28.

Is the individual and family support service available to people outside of the self-directed group?

Answer:

Yes, this service will be available to who participate in this waiver.

QUALITY

Question 29.

Frequency of quality assurance activities

Answer:

The Quality Assurance activities are the same throughout the waiver regardless of the payment mechanism. See Attachment III, Summary of New MRDD Waiver Quality Assurance Frame- work.

In short, Quality Indicators are monitored monthly, quarterly, semi-annually and annually. The QA/QE Committee meets monthly to discuss the data collected for that month, quarter and semi-annual indicators (as appropriate). The whole Quality Assurance Program is evaluated annually and new indicators are selected by the committee each January for the current year.

Question 30.

Provisions for periodically reviewing and revising its quality policies and procedures as necessary.

Answer:

The BCSS Quality Assurance Program has built-in systems for self evaluation and adjustment. When determined that revision of policies and/or procedures are needed, these revisions are made.

The Quality Assurance committee meets monthly to analyze data. If an indicator clearly meets threshold through three months, the committee decides whether to continue collecting data on the indicator or to retire the indicator. The committee identifies new indicators to track as a result of analysis of data. Therefore, the committee reviews the indicators on a monthly basis and makes decisions relative to revising the plan. The BCSS Director receives a copy of the committee minutes for comment each month.

In addition, the whole QA program is evaluated (polices and procedures for QA/QE) on an annual basis, each January. An Annual Report is prepared for the BCSS Director for distribution to stakeholders.

Other Quality Assurance Activities:

1. Review and approval of Case Management Agency QA Plans annually by the QA/QE Program Manager.
2. Review of the Case Management Agency's Self Evaluations on an annual basis.
3. (As Necessary) Deficient Practices identified through review of Critical Incidents (an indicator) and Complaint Investigations (another indicator) are recommended for citation of deficiencies through the BCSS Regional Office. A Plan of Correction by the agency is required (development of POC, the POC approved by BCSS, implemented by agency cited and results of implementation evaluated) before the deficiencies are cleared. The QA/QE Committee and the Service Peer Review Panel tracks the Deficiency Citations through resolution. (These citations are in addition or outside of the 5% monitoring process)
4. Customer Satisfaction Surveys (PLQ) will also be conducted through the Life Perspectives Team and reported to the QA/QE Committee on a bi-annual basis. The surveys will also be used for the DHH Customer Satisfaction Program.
5. Specific analysis of customer satisfaction surveys for the Consumer Direction Service Option will be provided to the Director for departmental management review. Program evaluation occurs annually. (*especially during the first three years prior to implementing the Service Option on a statewide basis)

Question 31.

Provisions for assuring that all problems identified by the discovery process will be addressed in an appropriate and timely manner, consistent with the severity and nature of deficiencies:

Answer:

Deficiencies (deficient practices) are identified through:

1. Critical Incident Reporting and Investigations conducted by BCSS Regional Staff
2. Complaint/Grievance Investigation by BCSS Regional Staff
3. Data Analysis by the QA/QE Committee on a monthly basis.
4. Once a week meeting of the Service Peer Review Panel for review of cases referred by Regional Staff.
5. Semi-annual 5% monitoring
   Deficient Practice Citations are made by the Regional Office staff as identified or as recommended by the multi-disciplinary QA/QE Committee or Service/Review Plan. (Note: Service/Peer Review Panel is a component of the QA/QE Program to assist the regional staff in making complex decisions)
6. Monthly/ Annual Review of Fiscal Agent functions.

The protocol for Deficient Practice Citations:

1. Immediate Jeopardy Situations: BCSS staff follows the Immediate Jeopardy Protocol for assuring the Individual's health, safety and welfare.
2. Substandard Compliance: Citation of Deficient Practices and a request for an Agency Plan of Correction (POC). BCSS recommends that POC includes QA/QI activities to monitor.
3. Substandard Compliance and/or repeat deficiencies: Citation of Deficient Practices and a request for a

Plan of Correction plus administrative sanctions such as: Suspending New Linkages and/or Monetary fines, Withholding Payment and/or Dis-enrollment as a Waiver Provider

4. Substandard Compliance in administrative area without impact to the Waiver Individual: Citation of Deficiency and a request for a Corrective Action Plan with a recommendation that an indicator be added to their QA/QI Plan for tracking (as part of their Corrective Action Plan) Tracking of Deficiency Citations by BCSS Regional Manager for all citations. QA/QE Committee and the Service/Peer Review Panel tracks all cases for which a

Deficiency Citation was recommended. Tracking by the QA/QE Program Manager is reported to members of the committee/panel and to the BCSS Director. Deficiencies are not cleared until all the actions in the approved POC have been implemented and cleared through follow-up by the BCSS Regional Staff.

5. Activities identified as barriers to consumer's achievement of personal goals or not supportive of the participant, (when the direct care staff are hired by the participant and not an employee of an enrolled Service Provide) will be addressed through the Individual Support Team with BCSS participation, if invited.

Question 32

More detail about the system to receive, review and act upon Critical events or incidents.

Answer:

Critical Incident Protocol and Toll-free Help Line (and MOU with APS)

1. Mandatory reporting of Critical Incidents:

WHO: Any person who has knowledge of an incident may submit a report to BCSS by FAX, or telephone (HOT LINE), by letter, or by a personal visit.

WHAT: Critical Incidents are those that allege that an individual is abused, neglected, exploited, or extorted, has suffered serious harm(emotional or physical) which if left untreated may result in permanent physical or emotional damage or death. (Includes illness with hospitalization).

WHEN: Critical Incidents must be reported to BCSS by an agency representative (service provider or case manager) within 2 hours of the first knowledge of the incident. If during the time when BCSS office is closed, the agency must fax or E-mail the initial report to the BCSS office and leave a voice mail message on the Toll-free phone line. The service provider and the case manager are responsible for the security of the individual. The Initial Report is followed up with an update (preliminary) in 72 hours of the event.

A Final Report must be submitted within 30 days of the event. The BCSS Regional Staff participates with the case manager in the investigation and resolution of the incident. They may cite any identified deficient practices identified.

TRACKING: Critical Incidents are reviewed and tracked by the Critical Incident/Help line/Appeals Program Manager and the QA/QE Program Manager to ensure appropriate intervention by all parties. (Both are RNs)

QUESTION 33

HOW WILL THE STATE MEDICAID AGENCY BE INVOLVED IN QUALITY?

Answer:

Through participation on the Medicaid Accountability Team and the development of quality indicators and outcomes measures reported to the Medicaid Team.

INDIVIDUAL BUDGETS

Question 34

The State's methodology for calculation of individual budgets – Including the minimum requirements that the methodology utilize actual service utilization and cost data

Answer:

The Protocol to be forwarded.

Question 35

The re-determination process

Answer:

As with all Home and Community-based Waivers, the CPOC must be updated annually and submitted with the pertinent documentation to support that the recipient continues to meet the level of care criteria. The Annual CPOC is a comprehensive document, which includes all information required for BCSS to determine that the participant continues to require all the services described in the CPOC. The information provided in the CPOC is also used to determine if the participant's health, safety and welfare needs can be assured or risk planning has been addressed and the service needs of the participant can be adequately met through the provision of the home and community-based waiver. Changes in service needs, identified between the approval and the expiration of the CPOC, can be approved through the submission of the Request for Revision to the CPOC (must be initiated by the recipient and facilitated by the case manager and the Circle of Support)

Question 36

Describe how the methodology is open to public inspection

ANSWER:

In compliance with Public Information Laws and HIPPA, confidential elements of the Individual's Plan are not open to the public. However, the processes utilized in the administration of the Home and Community-based Waivers are shared publicly through various stakeholder taskforces (who helped develop some of the processes) and through Systems Change Activities. In addition, the Life Perspectives Team will be instrumental in the assessment of the processes and methodologies involved in the implementation of the Consumer Direction Initiative (payment methodology)

PARTICIPANT PROTECTIONS

Question 37

The State has procedures to assure that families and individuals have the requisite information and/or tools to participate in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care.

Answer:

Training modules have been developed to assist all individuals and families to become informed on the principles of Self-Determination and on the process of self-directed services. Modules were developed by a team comprised of BCSS state office and regional staff, parents, self-advocates, and stakeholders (including advocates and representative of the advocacy center of La.).

Examples of modules developed are:
Self-Determination—What a Concept!
Understanding Consumer Direction
Supporting Choice & Responsible Decision Making
How to Choose a Provider
How to Hire and Train Staff
Training will be done collaboratively by representatives from Families Helping Families (a Family stakeholder group) and BCSS.

Question 38

The State will make available and provide services such as assistance in locating and selecting qualified workers, training in managing the workers, completing and submitting paperwork associated with billing, payment and taxation.

Answer:

The case manager and fiscal agent will be paramount in this process.
Specifically the Case Manager:

1. Offers each participant the Freedom of Choice for Service Providers or counsels in the selection of non-traditional providers.
2. In cooperation with the individual schedules and facilitates the CPOC person centered planning session.
3. Facilitates care planning and preparation of the CPOC, including the The Individual Budget.
4. Submits CPOC to BCSS for approval and Prior Authorization for Services.
5. Monitor service delivery as directed by BCSS policies and their case management contract with BCSS.
6. Updates the Individual=s CPOC for changes in service needs and annually.
7. Provides information on resources and advocates for the individual in identifying and obtaining formal and informal supports and services.

Fiscal Agent

1. Educates individual or responsible party on all aspects of Consumer Direction.
2. Provides the following services: payroll agent, payer of invoices, and monthly expense statements.
3. Bills Medicaid for the eligible services and pays the provider of the service.
4. Fiscal agents contracted through the RFP method must comply with requirements included in their contract.

QUESTION 39

The State has procedures to promote family or individual preferences and selections and these are appropriately balanced with accepted standards of practice. This balance requires deference to the individual whenever possible. Procedures will include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

Answer:

Risk Management Planning is a process required through the CPOC preparation and the CPOC must include the elements of Risk Management before it will be approved by BCSS. Individual Rights will be protected throughout the process. If there are clear disagreements between the Individual and the Individual's Support Team, mediation by BCSS may be required. If the Individual/Guardian/Family continues to strongly resist the Support Team's recommendations, the process of obtaining an agreement for resolution and obtaining applicable informed consent will be the next step. Education and Training will be provided regarding Individual Rights and the use of Informed Consent for assumptive risks.

QUESTION 40

The State has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

Answer:

The individual will receive monthly information on the use of resources and counseling/education by their case manager and the fiscal agent.

The case manager and the fiscal agent, in conjunction with BCSS, will monitor the budget monthly. The monthly reports from the fiscal agent will indicate the % of funds utilized to date.

Example follows:

Example: Date of: CPOC 5/16/01 Date of Report: 3/3/02

Service Description	CPOC End Date	Funds Budgeted	Funds Spent YTD	Remaining Balance	Remaining % of Funds
5hrs/daily 7days/weekly	5/ 16/02	$5,345.00	$4,015	$1,338.60	25%

This reporting system will allow for all involved to remain abreast as to the time remaining and amount of funds remaining for the CPOC period. The Individual and or family will be counseled and assisted in the management of funds based on individual circumstances. If a crisis arises, the case manager will, at the request of the individual, assist the in the implementation of back-up systems.

QUESTION 41

The State has procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination.

Answer:

Our motto will be, "take only what you need and pay only for what is received." We believe that each budget year brings with it new dreams, goals, plans and a new allocation. Any funds not utilized for an individual in a CPOC planning year will be documented by the fiscal agent. Our plan is to collect data for a three (3) year period and clearly demonstrate any savings this option has generated. This information will be valuable to the Louisiana Legislature's budget considerations for system funding in the future.

QUESTION 42

Describe your emergency back up systems in more detail.

Answer:

All Home and Community-based Waivers require that emergency preparedness plans and individual evacuation plans be part of the Comprehensive Plan of Care in order for the plan to be approved by BCSS. Along with the mandated emergency planning, the must be a backup plan for staffing. The individual and /or representatives, with the assistance of the case manager and the fiscal agent, will develop the back-up plan. This team will develop a plan that will indicate how the participant's needs will be met should the primary care assistant be absent for any reason. This plan may identify informal caregivers or identify an agency from which hours may be purchased (center based respite, etc). This plan should also include how needs will be met in the event of unexpected shortage of funds.

This process is evaluated on a monthly basis by the fiscal agent and on a quarterly basis by the case manager. There will be documentation as to the number of times the plans have been utilized and the success or lack of success of the plan. Adjustment will be made if the plan has failed for any reason.

ANSWERS TO JANUARY 10, 2003 CORRESPONDENCE
Request for Additional Information

APPENDIX B

Question 1.

In the definition of Professional Consultation please specify that training and consultation will only be provided regarding specific individuals' cases as opposed to general training sessions for the MR/DD Waiver.

Answer:

This clarification has been added to the Professional Consultation definition.

Question 2.

Are the service definitions the same when services are self-directed versus when they are provided through a traditional delivery system? If not, please provide definitions for each type of service.

Answer:

Services are the same for either the consumer directed/self-directed or the traditional delivery method. A note has been added to the beginning of Appendix B 1 to clarify that the services are the same no matter whether it is consumer directed/self-directed or the traditional delivery method.

Question 3.

The state proposes to impose benefit limitations on several services (specialized medical equipment, environmental accessibility adaptations, community integration development, professional services and professional consultation). What is the State's rationale for determining the appropriateness of the cost caps for each of the relevant waiver services?

Answer:

The specific services designed in this waiver request were based on recommendations of a task force comprised of consumers, advocates, service providers, case management agencies, DHH key staff and other stakeholders. The task force had a specific work group that worked with services including definitions and limitations. An analysis of potential needs and utilization patterns was completed. All the members of the work group and the larger task forced agreed with the services as defined.

The stakeholders task force expressed that the limitations were adequate. For example in the current MR/DD waiver, the cap for environmental accessibility adaptations is $3,000 lifetime maximum, the proposed waiver is $4,000 for only three years, once the individual has reached the $4,000 and at the end of three a new $4,000 is available to the individual. Note that on Appendix B 1 resubmitted on December 21, 2002, the following language was added: "On a case by case basis, with supporting documentation and based on need, an individual may be able to exceed this cap with the approval of BCSS and with the limits beyond the capped prior authorized." In addition person-centered planning will address all resources potentially available to the individual, including state only funds.

With specialized equipment the current limit is $5,000 for lifetime maximum, with the proposed waiver it is $4,000 for a three year period once the $4,000 limit is reached and at the end of the three years, the individual has another $4,000 available. Note that on Appendix B 1 resubmitted on December 21, 2002, the following language was added: "On a case by case basis, with supporting documentation and based on need, an individual may be able to exceed this cap with the approval of BCSS and with the limits beyond the capped prior authorized." In addition person-centered planning will address all resources potentially available to the individual, including state only funds.

For community integration services limit of 60 hours per month for 12 consecutive months was the recommendation of the work group and supported by the task force. The work group felt that would average 1 hour per week and they felt that was adequate as this service addresses establishing community networks, not the on-going participation in these networks which can be addressed with Individualized and family support services.

For professional services and professional consultation, the work group proposed a limit in order to assure that

the waiver maintained cost effectiveness. The task forced recognized that these professional services could become cost prohibitive and rather than lose the entire waiver for being out of cost effectiveness, the task force recommended setting limits. The $1,500 and the $750 were numbers that were agreed upon with consensus of the work group and the larger task force based on evaluations potential needs and utilization mentioned earlier. Also the following wording was added to Professional Services and professional consultation definition in Appendix B in the December 21, 2002 submittal: "If the individual reaches the cap before the expiration of the plan of care year and the individual's health and welfare are at risk, on a case by case basis and based on additional documented need for services, additional services can be prior authorized for approval." In addition person-centered planning will address all resources potentially available to the individual, including state only funds.

Question 4.

The State proposes to allow for a prior authorization process when an individual reaches a service limit. Is the prior authorization process triggered in all instances when participants reach service limitations or instead are there specific triggers? Please describe the state's prior authorization process.

Answer:

The states prior authorization (PA) process is designed to authorize services requested in the CPOC and rendered to the recipient. Waiver services will be PA'd before the services can be rendered and not intended to limit services, but to reflect services authorized based on the person-centered planning process and the CPOC when a person;s needs change the PA for the person changes. When services are needed beyond the proposed limits all resources potentially available to the individual will be accessed including state only funds. The PA's are based on the service needs on the approved CPOC. Currently, PA's are issued for a two week span. With the new MR/DD Waiver, PA's will be issued for a three month intervals, thus cutting down on the need for revision to the CPOC and allowing the family or recipient greater flexibility. BCSS will continue to PA all MR/DD waiver services based on the needs identified on the approved CPOC.

Appendix D-4

Question 5.

Please add form 90-L as a form used to document freedom of f choice.

Answer:

This has been added to Appendix D-4.

Appendix G-3

Question 6.

On the State's original application the State used information from a 372 that was not approved by CMS for Appendix G, further the information was on form 372 rather than the current 372s. The information was from LA0200 for 7/01/01 to 6/30/02. In response, GMS revived a 372s for the time period 7/1/00 to 6130/01. Can Louisiana submit a 372s for 7/01/01 to 6130/02? Also, the 372s sent includes case management as a waiver service. Case management is not an approved waiver service for LA0200. Case management is provided ar targeted case management to the waiver participants and therefore should be removed from waiver expenses on the 372s.

Answer:

This was a typographical error on the December 21, 2002 372 submitted, the dates should have been July 1, 2001 – June 30, 2002 and the case management should have been deleted. These changes have been corrected.

Question 7.

In Appendix G-3, what is Supervised Independent Living? 'This service is not listed in Appendix E.

Answer:

SUPERVISED INDEPENDENT LIVING IS THE NAME USED FOR "RESIDENTIAL HABILITATION" IN LOUISIANA AND HOW PROVIDERS OF THIS SERVICE ARE LICENSED IN LOUISIANA. A CORRECTION TO READ "RESIDENTIAL HABILITATION/SUPERVISED INDEPENDENT LIVING" WAS ADDED.

Question 8.

Appendix G.3 states, "No waiver services are furnished in the home of a paid caregiver..." However, the definition of adult foster care states services may be provided in a "private home by a principal care provider who lives in the home." Please clarify.

Answer:

Clarification noted as follows: "No wavier services, except Adult foster care/substitute family care, are furnished in the home of a paid caregiver, as this is in direct violation with Louisiana's licensing regulations."

Question 9.

In Appendix G3, please describe in detail the method for excluding room and board payments to providers. Please describe how the payment rates are set for the services listed in Appendix G-3, including the method for excluding the mom and hoard payment front this rate. This description should include the mathematical computation and data used to determine the cost of room and board and the mathematical computation and data used to exclude room and board from the provider rates. Also, the application should describe how providers are reimbursed for the room and board associated with these services. For example, the participant's SSI payment may be used to pay for room and board.

Answer:

Appendix G-3 has been corrected and rates showing mathematical computations are included with Appendix G-3

SELF -DIRECTION

Supports Brokerage

Question10.

In the State's Response to questions from CMS regarding the entity responsible for supports brokerage and its relationship with the Medicaid agency, what is meant by the statement that case management agencies "currently function within the Medicaid System as agents of the Bureau?" Please provide additional details about the relationship between the case management agency and the Medicaid agency.

Answer:

Louisiana's current waiver utilizes targeted case management for specific populations. For individuals with MR/DD targeted case management, the case management responsibilities includes planning, linking and monitoring the of the provision of direct HCB Waiver services and supports as well as services obtained from sources such as the Medicaid Program, other public programs and private sources. Other activities of the case management agencies include service/support planning (including assessment) and monitoring delivery of direct services and supports in order to ensure they are meeting the person's needs as well as to insure service delivery and satisfaction. The Medicaid Agency has agreements with Case Management Agencies to provide the services as stated above and monitors their performance. This system will not change with the new waiver, but expectations will be adjusted to address changing expectations.

For those waiver recipients choosing to participate in the Self-Direction Initiative, the case manager becomes the agent of the recipient for supports brokerage. The participant has full discretion in managing their services, the
case manager has the responsibility assists with the process.

The Case Manager, acting in their role as supports broker, assists by educating the family and individual about the service planning process, eliciting information from the individual or family regarding their preferences, goals and service needs, and assist with the identification of direct supports, community, public and private resources. This includes assisting the family or individual in identifying possible service providers, which may include people known to the family, such as extended family, neighbors, or others in the local community.

The case manager also has an important role in assuring the health, safety and welfare of the participant. The case manager, through mandatory reporting and
investigation of Critical Incidents and Complaints (re: direct services), assist
BCSS in oversight of waiver assurances. In addition, the mandatory quarterly meetings with the waiver participant/authorized representative provide opportunities for problem solving with the participant for any concerns identified.

BCSS will utilize the "Supports Brokerage" model as defined by CMS. BCSS QA/QI data will assist in the identification of additional roles and responsibilities that need to be addressed and added to enhance services.

Question11.

Existing case managers will provide supports brokerage activities. Will additional training be offered to these individuals regarding self-direction and new duties including monitoring the individual budget, assisting the program participant to locate resources and coordinating with the financial management agency? Who monitors the activity of the case management providers? Will the existing rate paid to change for supports brokerage?

Answer:

Training will be provided to Case Managers and Direct Service Providers as part of a required program of training regarding the principles of self-determination. For those case managers who are directly involved with recipients who have selected the consumer direction option, additional education on changing roles and responsibilities will be provided. BCSS has developed training modules addressing a wide range of related topics with the help of stakeholders. Education will be offered to recipients, families, case

managers, and providers. In addition, case managers and other stakeholders will be provided the opportunity to attend joint training activities that will be offered as a collaborative effort between DHH and a stakeholder group of families called Families Helping Families to recipients and families in their home DHH Region.

See Answer for Question # 12 for details.

Case management agencies are monitored through several avenues. This includes a self-assessment process for the development of agency-specific QA/QI Plans, mandatory Medicaid reporting (CMIS), annual self-evaluation reports, compliance reporting and monitoring, annual licensure surveys and semi-annual monitoring by BCSS. Case Management agencies are paid according to their provider agreement with Medicaid. It is anticipated that the existing rate paid and case requirements for case management agencies will continue to be adequate, since components of supports brokerage is already a requirement in their agreement with Medicaid and other changes will be addressed through policy and procedure.

Question12.

How will the state offer practical training to enable families and individuals to remain independent? Examples of training include providing information on recruiting and hiring workers, managing workers, and providing information on effective communication and problem solving. The function provides sufficient information to assure participants and their families understand the responsibilities involved with self-direction and assist in the development of an effective backup and emergency plan. If the state plans to use supports brokerage service for these activities, how does it plan to comply with the State Medicaid Manual.

Answer:

BCSS, in conjunction with Families Helping Families (FHF) (see above), has designed training modules to be used for the participants and their families. BCSS will train participants as the individuals select the consumer direction option.

FHF will conduct training programs in collaboration with BCSS related to waiver services, to individuals with disabilities, and their families or authorized representatives as well as case managers, providers, and other interested individuals who may be interested in the consumer direction option. Training will include the following topics:

- Understanding and Supporting Consumer Direction
- Shattering Stereotypes
- Supporting Choice and Responsible Decision Making
- Remembering Who the Customer Is
- How to Hire, Train, and Direct Supports
- How to Choose a Provider
- The Road to Self-determination-A History of Disabilities
- General Information about the New Waiver.

All training modules include a syllabus, objectives, and desired outcomes, course content, audiovisuals and competency based/results driven outcomes. BCSS in collaboration with FHF will make necessary adjustments/additions to the training modules based on changes in Waiver Services and feedback from participants participating in the training sessions and reports from FHF.

Meetings will be conducted according to a schedule developed by BCSS and FHF in locations across Louisiana and at times convenient to participants. The schedule will include opportunities for training on each of the core modules listed above in each parish and region of responsibility. FHF will initially strive to train up to 80% of the recipients (unduplicated) and no less than 50% (unduplicated) of recipients who choose to participate in the Consumer Direction/Self Direction Initiative. FHF has agreed to maintain confidentiality in regards to recipient information and will abide by HIPAA Requirements and Louisiana State law.

BCSS and Families Helping Families will provide training to the individuals and their families, case

managers, direct support workers, service providers and fiscal agent to assure that sufficient information is provided to participants and their families so that they will understand the responsibilities involved in self direction. The case manager and the fiscal agent have a role in assisting and supporting the individual and their families in recruiting and maintaining qualified direct support staff. Quality Assurance/Quality Enhancement Program's activities will identify needs for additional training, further changes needed in roles and responsibilities and/or technical assistance.

Case Management agencies, under the terms of their agreement with Medicaid, have requirements as part of the planning process that assures emergency back-up systems are in place for each individual served. In addition to these individualized plans, the case management agency must maintain 24 hour on call staff available at toll-free numbers to address recipient needs and emergencies as well as disaster emergency systems that go into effect during local emergencies and state/national emergencies to identify which individuals need support in disaster emergencies. The case management agency, under terms of their agreement, must assure each recipient practices/fire drills in emergency procedures as described in their agency policy. The result of this planning must be reflected in the Individuals/Participant's Comprehensive Care Plan (CPOC). BCSS will not approve the CPOC without an Emergency Plan.

Targeted Case Management is not in conflict with the State Medicaid Manual.

FINANCIAL MANAGEMENT SERVICES

~~Question13.~~

~~Are financial management services claimed to the Federal Medicaid Program as an administrative costs or a waiver service?~~

~~Answer:~~

~~See Appendix F of the Waiver Document. The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims. All claims will be processed through an approved MMIS.~~

~~The Fiscal Agent will bill a monthly rate per recipient for services provided to cover administrative and processing costs based on contracted rates determined by an RFP. Reimbursement to the financial management agency will be made through claims submitted to the Medicaid Fiscal Intermediary for payment upon the completion of each monthly service.~~

Question 14

Will the contract with the financial management agency specify that routine contacts with the case manager be required?

Answer:

In order to be in compliance with their agreements with Medicaid, the case management agency and the fiscal agent must be in contact for monitoring activities no less than on a quarterly basis and more often as needed to ensure services are being provided as planned in the CPOC and Individual Budget. BCSS requires monthly MMIS reports from both agencies and a coordination of information at that time.

Question 15

The state asserts that the financial management agency does not complete taxes but prepares the forms for the individual employees. The financial management agency does, however, withhold payroll taxes for IRS for the direct service professional employed through an agency. Please clarify.

Answer:

The fiscal management agency (Fiscal Agent) pays invoices for services based on the approved CPOC and Individual Budget. The Fiscal Agent will process the invoices monthly and make necessary withholdings tax/payroll/audit functions and ensure prompt payment to the providers. When the direct support staff is not an employee of an enrolled Medicaid Service provider, the fiscal management agency functions as an employer would function by withholding payroll taxes and preparing the W-4 form, the W-2 forms and state income tax forms for federal and state income taxes. The fiscal management agency does not prepare

IRS forms for filing the income taxes.

COMPLIANCE WITH FEDERAL REQUIREMENTS

Question 16

Louisiana asserts that the Louisiana Medicaid office holds the provider agreement. Do the direct providers of services hold provider agreement with the Medicaid agency?

Answer:

Louisiana's provider agreement (Louisiana's Medicaid Program Provider Enrollment Form) is signed as part of the enrollment process for waiver services. The provider agreement between the service provider agency and Louisiana Medicaid requires a signature of the service provider/administrator and by which the agency agrees to meet the requirements listed. See attached copy of the BHSF Form PE 50.

Question17.

In Louisiana's description of its payment to providers, the State asserts UNISYS will send check to the financial management agency each month to cover the cost of the authorized services. The consumer and case manager will arrange for the services to be provided and invoices will be sent to the financial management agency for payment. The financial management agency then processes the invoices monthly and makes payment to service providers and reimbursement for waiver services. CMS remains unclear whether the provider receives the payment directly from the Medicaid agency. It appears all funds go to the financial management agency and are disbursed from there. Provider agreements and direct payments to providers' requirements would not be met under this system unless an organized Health Care Delivery System (OHCDS) is in place, Additional information regarding an OHCDS is attached. An OHCDS is defined at 42 CPR 447,10(b) as, "...a public or private organization for delivering health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization." Section 447 (0(g)(4) recognizes an organized health care delivery system as an entity to which Medicaid payment may property be made. Also, it appears that there may be as much as a 30-day lapse between the provision of services and when the providers are reimbursed. If this is correct, does Louisiana feel confident sufficient providers will be identified to perform the needed services?

Answer:

See Appendix F. The Medicaid agency will pay providers through the same fiscal intermediary (UNYSIS) used in the rest of the Medicaid Program, and
the Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver services for those waiver participants who choose to participate in the Self Direction Initiative.

By their agreement , the fiscal agent must have systems and resources adequate to be able to accept payroll, bill and pay providers within a fourteen day turnaround.

~~Question18.~~

~~In Louisiana's response to CMS's first set of questions in the Self Direction Attachment under the heading support staff, the State asserted the program participant may select from two options when hiring a direct support provider 1) he/she may serve as the employer of record and hire directly or 2) select personnel and have a "provider" serve as the employer of record (Agency with Choice model). In Louisiana's response to CMS's second set of questions (#25), the application states only the financial management agency can be the employer of record. Please clarify~~

~~Answer:~~

~~A participant may choose to hire a direct support staff through an enrolled Medicaid Service Provider or hire a person not affiliated or employed by another agency. If the direct care service provider is an individual not affiliated or employed by an enrolled service provider, the waiver recipient may choose to enter into an employment relationship with that direct support provider. In the case of the unaffiliated direct care support provider, the criminal background check must be obtained. The financial management agency obtains the background check for the waiver participant, assures the proper payroll withholdings, prepares the income tax (W-4, W-2 forms and Louisiana Income Tax Forms) forms related to the~~

~~withholdings, and maintains the competency-based training resource manual and records for the unaffiliated direct support staff hired by the waiver participant.~~

~~In contrast, if the direct support provider is employed by an enrolled Medicaid Provider, the responsibilities for the obtaining the criminal background check, providing the payroll functions, payroll withholding, the provision and maintenance of the competency-based training record lie with the enrolled Medicaid Provider.~~

~~In either case, the participant, with assistance from the fiscal agent, controls the payment and agreements for services to be provided.~~

Individual Budgets and Plan of Care

Question 19.

The State has asserted, the budget must be needs based and reflect the individual needs and desires of the person with disabilities as determined in the person-centered planning. Budgets must be flexible, within the approved amount and CPOC, to move dollars from one line item to another or create new line items as needed to maintain the individual's support and provide for personal crisis situations." What method of communication is in place for individuals to take advantage of this flexibility' Do they call the case manager, meet with the CPOC team, or do they exercise another approach?

Answer:

The waiver participant would contact their case manager to prepare a CPOC Revision Request, which would outline the proposed changes to the CPOC and the Individual Budget. The CPOC Revision Request, signed by the participant, is then sent to BCSS for review. The approved changes would be reflected in the new Prior Authorization for Services, which authorizes the payment of the services.

If the requested change constitutes a significant change in the waiver participant's CPOC, then of course, the Support Team would convene to address the needs and prepare a revision or a new CPOC

Question 20.

Louisiana states, "The Prior authorization process will allow authorization of services for a quarter span of time, giving families flexibility with funding and utilization of services. In addition, the CPOC and its revision process allows for the same flexibility." What if the individual wants to make changes to the individual budget or CPOC before the next quarter span of time or an emergency arises requiring a change to the individual budget or CPOC before tire next quarter span arises? What will be the method of communication to make changes to the individual budget or the CPOC before tire next quarter span of time? Also, please reconcile with the previous question

Answer:

The Individual can make changes at any time they desire by using a
CPOC Revision Request to change their Comprehensive Plan of Care and Individual Budget. This mechanism has worked for the current waiver and should not pose a problem with the new waiver. The case managers are already using this mechanism to request change of authorized services for waiver participants. Emergency changes are approved retroactive, if the Case Manager cannot obtain the approval before the need occurs. Otherwise, emergency revisions are requested and approved within 24 hours of rendering emergency services.

Question 21.

The State will approve *all* CPOCs and Individual budgets and any changes. Does Louisiana anticipate this being a timely process? What will happen in emergency situations?

Answer:

See number 20 answer.
The mechanism for changing the CPOC has been used in the current waiver and we anticipate it working for the new waiver. Emergency revision requests are given priority by the regional office staff and may be approved verbally by phone with hard copy to follow, if necessary. We are also developing and electronic

system that will use electronic transmission and/or fax to spend up communication for all approvals but especially for emergency revision approvals.

Routine CPOC Updates (annual) are submitted within 30 days of expiration. BCSS has a time line of 10 days to review and approve the CPOC.

Question 22.

When asked, `is the individual and family support service available to people outside of the self-directed group?' the State responded, "Yes, this service will be available to who participate in this waiver." Should this read, "Yes, this service will be available to all who participate in this waiver?"

Answer:

Yes, the word “all” was omitted erroneously. Please add to the sentence.

Question 23.

Of those selecting the self-direction option-if they wish to transition from self-direction to traditional services- what will the process be and how long will it take?

Answer:

An individual requesting to be removed from the Consumer Direction Project and return to services provided directly by a direct service provider using the MMIS/Payment System may do so at any time by submitting a new CPOC, developed with their Support Team. The new CPOC will indicate the services and supports desired. The new CPOC will be approved within 10 days of submission, unless deemed an emergency.

Question 24.

If training of the direct care staff is necessary, the cost for this is deducted from the individual budget. However, Louisiana retains the right to determine the level of training and qualifications needed by the individual provider. If there is disagreement between the program participant and Louisiana about the level of training, what happens?

Answer:

Level of training is to be based on the needs of the participant. Only very basic training such as CPR/ First Aid will be needed by direct support workers. The rest of the training will be based on the specific needs of the recipients with some of the training being provided by those who are directing their care. If there is a disagreement between the program participant and Louisiana about the level of training required, a meeting to address this will be held. Should further disagreement be identified after this, a Support Team meeting will be requested and the issue will be discussed relative to the needs and desires of the individual receiving the waiver supports. If the Individual’s Support Team concurs that the training, requested by BCSS, is not necessary for this individual’s support, the issue will be referred to the BCSS Quality Assurance/Quality Enhancement Program Service/Peer Review Panel for review. As part of the resolution process, BCSS may request that a multidisciplinary panel, which meets weekly respond to the Regional Staff on the same day, it meets. This panel includes various stakeholders and managers, who have the authority to make the decision to waive the requirement.

Question 25.

What is the State's methodology for the calculation of individual budgets, including the minimum requirements that the methodology utilize actual *service utilization* and cost data? How does the State re-determine individual budgets? The State has described the re-determination process for the CPOC but not the individual budget.

Answer:

BCSS plans to use the person-centered planning process to identify the needs and desires of the individual as the basis for the individualized budget. The planning process includes identification of personal outcomes and participant-specific information as well as evaluations as a part of this planning process. A tool that will document the base-line of needs identified will be used to support requests and changes in the preparation of the Individual Budget. This tool will provide a standard means of documenting the requests

in the Individual Budget. The Individual Budget is the end result of the CPOC process completed by the Participant and the Individual Support Team. The Individual Budget is arrived at by identifying the individual's service and support needs, identifying natural supports, identifying all available public and private supports and using person centered planning. In subsequent years, the previous year's budget will be the starting place for developing the new budget.

~~Question 26.~~

~~Regarding unexpended resources in the individual budget, what happens to excess funds in each individual's budget? Will individuals be allowed to spend/save any left over money in the following year? Will left over money go to a general pool?~~

~~Answer:~~

~~Medicaid funds will be used to pay for service and supports rendered to the Individual as authorized in the CPOC and the approved Individual Budget. Funds not identified in the CPOC and Individual Budget will not be drawn down and remains with Medicaid. As this initiative has a three-year phase-in, it is Louisiana's intent that information and results obtained for the monitoring of this new system will provide options for the service system of the future.~~

Quality Assurance

Question 27.

In the State's provisions for assuring that all problems identified by the discovery process will be addressed in an appropriate and timely manner, consistent with the severity and nature of deficiencies, the State listed several types of situations, each of which has different protocols. The situations listed are; Immediate Jeopardy Situations; Substandard Compliance; Substandard Compliance and/or Repeat Deficiencies; Substandard Compliance in administrative area without impact to the waiver individual; Activities identified as barriers to consumer's achievement of personal goals or not supportive of the participant. Please define each situation or provide an example of each. How does the State determine which situation applies? What are the State's provisions for assuring that all problems are addressed in an appropriate and timely manner? Are there time frames for each of the protocols? Please provide a copy of the Immediate Jeopardy protocol.

Answer:

Upon receipt by BCSS of evidence of non-compliance with provisions of participants CPOC and individualized budget, and/or provider agreements, rules, regulations and/or standards for payment applicable, the Bureau will act on the concern and apply necessary corrections.

See Immediate Jeopardy Guidelines, Deficiency Citation Protocols and Self Direction Option Protocols attached.

Question 28.

Does the State train individuals and/or their families in managing workers?

Answer:

Yes, BCSS in conjunction with the Case Manager, Fiscal Agent and Families Helping Families (FHF) will train individuals and families in managing workers.

Question 29.

When describing individual risk management planning the state asserts the elements of Risk Management must be included in the CPOC. What are the elements of Risk Management?

Answer:

Risk Management begins with the person centered planning process and the Support Team meeting, where the service and support needs are identified for the waiver participant. As part of the person centered planning process, desired outcomes related to health, safety and welfare are identified and included in the CPOC. A required component for every CPOC is an emergency

plan which includes a plan for back-up staffing, a Disaster Plan and an Emergency Evacuation Plan. The CPOC identifies the level of support needed to implement any of these plans.

Another component of Risk Management is the required reporting
policy and procedures for Critical Incidents. All Critical Incidents are reviewed, evaluated, and/or investigated by BCSS regional Staff. Plans of correction are required for unresolved concerns. BCSS maintains a toll-free help line that accepts complaints from stakeholders. The Help Line Program Manager and the QA/QE Program Manager track trends and patterns of Critical Incidents and complaints. These tends are reviewed by the QA/QE Committee and concerns regarding participants are addressed through the planning and case management system while systemic concerns are submitted to the BCSS Director for evaluation of and correction of system processes.

Individuals who are at High Risk for health and welfare concerns are identified by BCSS regional staff or QA/QI oversight for more frequent monitoring by BCSS. The recipients may be identified as a result of the frequency and type of Critical Incidents, fragile medical condition of the recipient, Abuse/Neglect Complaints and/or at the request of case managers or BCSS staff, who have concerns about the recipient. BCSS, in conjunction with the State's Adult and Child Protective
Agencies, investigate all allegations of Abuse (of any kind) and
Neglect. Interagency agreements allow for collaboration in Complaint Investigations and report systems involving waiver recipients.

Question 30.

Louisiana will make home visits to 5% of randomly selected program participant's homes. That translates into five home visits for the first year. Does LA feel confident this is sufficient?

Answer:

BCSS currently makes home visits for all new waiver recipients, prior to approving the Initial CPOC. In addition, BCSS staff makes home visits to no fewer than 5% during the semi-annual monitoring activities. However, in addition to the identified 5% sample, BCSS visits all designated High Risks Recipients. The BCSS regional staff also reviews and may investigate complaints or Critical Incidents by conducting a home visit where applicable.

We apologize for not providing a sufficient picture of our plans for visiting those waiver recipients choosing the Self-direction Option. In addition to increased oversight by the BCSS monitoring team, case managers will visit with the recipient, face to face in their home at least quarterly. BCSS will use contractors and other stakeholders called the Life Perspectives Teams to complete Consumer Satisfaction Surveys. These teams will be made up of waiver advocates, self-advocates, and family members. This Team will conduct face-to-face interviews with participants in or out of the recipient's home, as desired by the recipient.

Question 31.

The targeted case manager will be responsible for evaluating consumer satisfaction with their services and supports. How will the consumer's satisfaction with the case manager's services be determined? How will a conflict of interest be avoided?

Answer:

Yes, the targeted case manager has a responsibility for evaluating consumer satisfaction with participants. To avoid conflicts of interest and validate the Case Management Agency's self assessment which also addresses the agency's satisfaction ratings, BCSS staff during monitoring contacts as well as the Life Perspectives Team visits will complete satisfaction reviews. While focusing on all parts of the service system, individual focus is directed to case management due to the importance placed on this part of the service system.

Evaluation of consumer satisfaction with all waiver services will be done for 100 percent of those waiver participants choosing the self-direction initiative. The Life Perspectives Team will survey various waiver recipients on no less than a quarterly basis. (See description previously submitted of the Life Perspective Team and the PLQ) Interviews with waiver participants and their families are done during all BCSS home visits to determine satisfaction with Case Management Services as well as Direct Service Providers.

In addition, BCSS semi-annually conducts Consumer Satisfaction Surveys relative to all services including Targeted Case Management, Direct Service Providers and BCSS services as part the Louisiana Department of Health and Hospital Customer Satisfaction Plan and the BCSS Quality Assurance/Quality Enhancement Program.

BCSS is confident that we will have reliable data concerning consumer satisfaction with the consumer direction option as this has been part of on-going discussions with stakeholders since the planning process began.

FOLLOW-UP TO QUESTIONS RELATED TO RAI DISCUSSION DURING CMS CONFERENCE CALL OF FEBRUARY 10, 2003

Question 1

What will be the effective date of the waiver?

Answer.

April 1, 2003 is the request date for implementation.

Question 2:

In regards to benefit limits, the State asserts, "On a case by case basis, with supporting documentation and based on need, an individual may be able to exceed this cap with the approval of BCSS and with the limits beyond the cap prior authorized." We asked the State to describe the prior authorization process and when it is triggered in question 4 of the RAI. The State described their prior authorization process for services in general. How is this process different from the prior authorization for services when the individual reaches the benefit limit. Does the process begin when the individual needs more services? What is the State's criteria for prior authorizing services in excess of the cap? What happens if the services are not authorized? What protections are in place to ensure that the individual is able to remain in the community and avoid institutionalization? How long does the process take before an individual can receive additional services?

Answer:

Outlined below are the procedures established to address your questions relating to the statement below related to benefit limits: "On a case by case basis, with supporting documentation and based on need, an individual maybe able to exceed this cap with the approval of BCSS and with the limits beyond the cap prior authorized."

Authorization Process:
Louisiana's HCB waiver programs places several system safeguards built into the quality assurance system that allows for supporting individuals as their needs change.

Person Centered Planning
The system begins with the person-centered planning process that identifies the individual's needs and requested personal outcomes. The Comprehensive Plan of Care (CPOC) compiles this information into a planning document that addresses the individual's needs and the level of care required to support the individual safely in the community. The needs of the individual and services identified in the CPOC that have a benefit limit will be reviewed at a minimum of quarterly by the individual's case manager.

Case Management
Case management requirements in Louisiana are focused on the support of the individual and quality assurance including the health and welfare of the individual. Case Manager ratios can be no greater than 1 to 35. This allows for the case manager to get to know the individual personally and QA systems require that the Case Manager meet face to face with the individual at least quarterly to review needs, satisfaction and progress. In addition, the case manager visits the individual at a minimum of quarterly during recipient of services to address progress and satisfaction.

In addition, semi-annually, individual's who are determined to be at high risk or are identified through the 5% random sample are reviewed for the adequacy of the supports received. This may also prompt the review of the individual's needs and the CPOC.

Planning Revision Process

Who: Anytime an individual's needs change the case manager updates the CPOC. There are several methods that trigger this process. Case Managers may begin the process anytime that they observe that the individual's needs have changed. Families or recipients may inform the case manger that they believe that their needs have changed and that a revision is needed. Families may contact the BCSS help line if they feel that they need direct assistance from BCSS. Direct Service providers may contact the case manager or BCSS should they identify that the individual's needs have changed. BCSS or Life Perspectives teams may recognize that the individual's needs have changed and the revision process maybe initiated through this process.

How: A planning meeting with the individual and their circle of support will be called to evaluate the waiver supports that the individual is currently receiving, progress and needs that are necessary to assist the individual in continuing to live in the community. The planning process must address the availability and utilization of all natural and community supports in addition to Medicaid state plan services, state funded services and other resources available to the individual. A new needs assessment and plan of care will be developed and requesting that the service limit be exceeded for a specific period of time. When the individual's service limit is involved in this process and it is determined through the planning process that the individual's needs have changed and that the individual is at risk for institutionalization without the services that have service limits, a request may be made to exceed the service limit. Emergency requests will receive authorization immediately and routine requests will be processed within 10 days. The authorization for individuals to exceed the service limits is consistent with the process used for other service approvals. If an individual's health and welfare cannot be reasonably assured by the formal supports available in this waiver and informal supports available from the circle of support and community as well as other state funded programs; service limits may be exceeded. Should the need for extraordinary services continue beyond 90 days, and planning efforts have not reasonably assured that the individual's health and welfare is no longer at risk, then the individual will be disenrolled for this reason and service discharge planning shall include an offer of ICF/MR services. Individual's disenrolled for this reason shall be given the right to a fair hearing through the grievance process.

Grievance Process
Should the individual or authorized representative object to the authorized services that result from the request, the grievance procedure that includes a fair hearing may be accessed.

Question 3.

The State asserted they used the HCFA 372s for D' in Appendix G. However, D' in 372s and D' in the waiver are different. Please clarify or make changes if necessary.

Answer:

The 372 has been corrected.

Question 4

In Appendix G-2 Item 4, RN & LPN, Column E should be 625,260, not 625,620. Please make this change, and changes to the grand total and factor D for each year.

Answer:

This has been corrected.

Question 5.

In question 9 of the RAI regarding Appendix G-3, we asked the State to describe in detail the method for excluding room and board payments to providers, including the mathematical computation and data used to determine the cost of room and board and the mathematical computation and data used to exclude room and board from the provider rates. Louisiana used the hourly rate for providers to calculate the Center-Based Respite Rate, an annual payment to the SFC family to calculate the rate for substitute family care, and a provider salary to calculate residential habilitation/supervised independent living. Please describe what was considered when determining the hourly rate, annual payment, and salary.

Answer:

Rate calculations for these services are based on historical information regarding rates, input from key state holders that help develop the waiver and review of national trends. Rates and per diem paid for substitute family care services, center based respite, and residential habilitation/supervised independent living do not include payments for room and board as evidenced by the low rate per hour for each of these services. The $39 per diem ($1.62 per hour) for Substitute family care, the $11.50 per hour for center-based respite, and $20 per diem (.83 cents an hour) for Residential habilitaion/supervised independent living. The cost of room and board are paid by the participant through an arrangement with the participant and the service provider in Substitute Family Care and Center Based Respite to cover the room and board through the participants' SSI with allowances made for personal needs. In Residential habilitation/supervised independent living the room and board is the responsibility of the participant.

Question 6.

Please provide examples of facility based employment in Appendix B. Also, please consider naming the service employment related training.

Answer:

The service has been renamed to employment related training and the following is the definition and examples of employment related training. Employment Related Training are services not Available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602 (16)and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16and 71). Services are aimed at providing individuals opportunities for employment and related training in work environments in accordance with U.S. Dept. of Labor regulations and guidelines. Employment related training services include related training designed to improve and/or maintain the individual's capacity to perform productive work, and function adaptively in the work environment.

Examples include:
An individual receives assistance and prompting in the development of employment related skills. This may include assistance with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, and behavioral support needs and any medical task which can be delegated. An individual is employed at a commensurate wage at a provider facility for a set or variable number of hours. An individual observes an employee of an area business to obtain information to make an informed choice regarding vocational interest. An individual is taught how to use a vacuum cleaner. An individual learns how to make choices and order from a menu at a fast food restaurant. An individual is taught how to observe basic personal safety skills. An individual is assisted in planning appropriate meals for lunch while at work. An individual learns basic personal finance skills. An individual and, as appropriate, his/her family receive information and counseling on benefits planning and assistance in the process.

Question 7

Louisiana plans to have the targeted case manager become the supports broker. Targeted case managers should not provide additional services, other than case management, or work for an agency that can provide additional services. These duties may present a conflict of interest in that the case manager may encourage the participant to use the services that the case manager is affiliated with. Do the case management agencies provide services in addition to case management? Can case managers provide services in addition to case management? If so, how does the State prevent a conflict of interest?

Answer:

There is no opportunity for Conflict of Interest. The Case Management Agencies may not provide any other services. They are selected through a Freedom of Choice process and they in turn provide the applicant with a list of Service Providers from whom they make their Freedom of Choice. The case management agencies and Case Managers are not affiliated with enrolled Waiver Service Providers.

Question 8

In question 30 of the State's response to the RAI, the State mentions Life Perspectives Teams. The team conducts face-to-face interviews with participants and helps them fill out consumer satisfaction surveys. The teams are made up of waiver advocates, self-advocates, and families. CMS requires that states offer advocates for participants in self-directed programs. Please provide more information about the Life Perspectives Teams to determine whether they meet this requirement.

Answer*:*

The state has several advocacy groups such as Families Helping Families and Louisiana ARC, who are independent from state services. These stakeholders participated in the development of the New Opportunities Waiver and the Consumer Direction Initiative. In addition to the routine oversight by the BCSS monitoring team, case managers visit with the recipient, face to face in their home at least quarterly and per their unique role, advocate for the individual. BCSS will also utilize the services of other stakeholders in the form of the Life Perspectives Teams to meet with the consumer and complete a Satisfaction Survey and advocate for individuals if the need arises. These teams will be made up of waiver advocates, self-advocates, and family members. This Team will conduct face-to-face interviews with participants in or out of the recipient's home, as desired by the recipient. These teams will be identified and supported by our FHF organization under the direction of BCSS. This information will be forwarded to BCSS which will allow for the identification of problems for the individual and for the system. This process will enable us to identify trends/patterns and problem solve for the individual and the system.

Question 9.

Advocacy, training, and enabling a program participant to manage an individual budget and locate, access and coordinate the needed services are key elements of a self-directed waiver, and are typically associated with the supports broker function. Louisiana has associated these elements with several different entities. How will the State ensure these functions are coordinated?

Answer:

The Comprehensive Plan of Care (CPOC) is the result of person-centered planning by the Individual and their Individual Support Team. The case manager is responsible for initiating and facilitating the planning meeting. The support needs are identified during person centered planning and the Comprehensive Plan of Care (CPOC) is developed.

The Case Manager submits the CPOC for review and approval by BCSS. The Fiscal Agent may or may not be present at the Team meeting, as desired by the Individual. The case manager makes sure the identified service needs are available and assists the individual in arranging the services. It is also the responsibility of the Case Manager to work in coordination with the Fiscal Agent in assisting the Individual to purchase needed services and ensure the services are provided according to the CPOC. The case manager is the coordinator for plan development and service provision.

Question 10

In question 12 of the State's response to the RAI, the State asserts "FHF will initially strive to train up to 80% of the recipients and no less than 50% of recipients who choose to participate in the Consumer Direction/Self Direction Initiative." What happens if 100% of the consumers want training?

Answer:

BCSS, in conjunction with Families Helping Families (FHF) (see above), has designed training modules to be used for all MR/DD Waiver participants and their families. Meetings will be conducted according to a schedule developed by BCSS and FHF in locations across Louisiana at times convenient to participants. Although our goal is to have 100% of all waiver recipients trained, due to financial and human resource limits, FHF will initially strive to train up to 80% of the waiver recipients (unduplicated) and no less than 50% (unduplicated) of all recipients. For those who choose to participate in the Consumer Direction/Self Direction Initiative we anticipate that 100% participation in training. Although we are not mandating that all recipients participate in all modules, we are going to mandate that 100% of recipients have an opportunity to review modules or an alternate format including necessary information to participate in Consumer Direction Option including regularly scheduled meeting with Fiscal Agent to gain an understanding of rights and responsibilities related to the options.

Question 11.

Please clarify question 13 of the State's response to the RAI. Are financial management services claimed to the Federal Medicaid Program as an administrative or waiver cost? CMS permits the financial management service to be matched as either an administrative or service cost. In the response, the State asserts "Reimbursement to the financial management agency will be made through claims submitted to the Medicaid Fiscal Intermediary for payment upon the completion of each monthly service." Does this mean the Financial management service is matched by the federal government as a service as opposed to an administrative activity? If so, it must be listed in Appendix B and G as such.

Answer:

The fiscal agent function is a payment mechanism and is not considered a "service". Therefore, it would be an administrative cost and not viewed as a waiver service cost as the fiscal agent functions in an administrative capacity and not in a "service" delivery capacity.

In Louisiana we want to begin the process of consumer direction small, phasing this new direction into three regions of the state expecting that a limited number of people will participate. This will allow Louisiana to establish a solid base to insure that the vision this procedure was built upon, that of self determination will have the maximum chance of success and that the objectives of all involved; the people participating in this waiver, the state, the federal government will be met. This will allow Louisiana to build system capacity, develop an infrastructure that will adequately support this process, gather data for a three year period that will be used to continually improve the system, and work out any kinks in the process as we continue to expand the program statewide. To try to establish this as service that would have to be offered on a statewide basis using enrolled providers would set our vision and the recipients

up for failure.

Question 12:

Please clarify the State's response to question 18 -- Who is the employer of record, the financial management services agency, or the individual? The application is inconsistent.

Answer:

The employer of record will be the fiscal agent for consumer directed services. The recipient will direct their care including hiring, firing and evaluating those providing their services; however, the responsibility for the payment for services and legally mandated fees to meet fiscal and fiduciary responsibilities is the function of the fiscal agent.

Question 13

In regards to question 25 of the State's response to the RAI, the State asserts the budget is created by identifying the needs of the individual. How are the needs of the individual associated with a dollar amount? For example, after the State identifies what the individual needs, are the services costed out based on the average cost for those services, or perhaps, is the individual put in a category based on need which is associated with a budget amount?

Answer:

BCSS plans to use the person-centered planning process to identify the needs and desires of the individual as the basis for the individualized budget. The planning process includes identification of personal outcomes and participant-specific information as well as evaluations as a part of this planning process. The Individual Budget is the end result of the CPOC process completed by the Participant and the Individual Support Team. The Individual Budget is arrived at by identifying the individual's service and support needs, identifying natural supports, identifying all available public and private supports and using person centered planning. This level of care/needs is then applied to the services provided by the waiver and rates/cost per service are applied and the entire budget for the year is developed. In subsequent years, the previous year's budget will be the starting place for developing the new budget.

Question 14:

In regards to question 26 in the State's response to the RAI, what if funds are identified in the individual budget, but not spent? For example, if the individual budget was for 30K and the individual only spent 25K, what happens to the extra 5K?

Answer:

The individual's budget is based on the needs of the consumer and not a dollar value. If the individual's budget identifies the individual's needs to be $30,000 and subsequently during the year the individual only needs $25,000 and spends $25,000 then we would pay for $25,000 in services. The individual will have received what they need and the DHH has paid for nothing more. The Waiver is not an entitlement program, but based on the needs of the individuals. Therefore, we do not see that the individual has lost $5,000, but only that they have received what was needed. The remaining $5,000 would be available for other participants in the waiver who have needs or to address services needed by those yet to be enrolled in the waiver. In reality we want people to access only what they need and shift from the thinking, I am entitled to $30,000 and I am going to spend $30,000. Instead, realize I have $30,000 that can be accessed, but at this time my need was only for $25,000.

Answers to Questions from CMS E-mailed 2-21-03

Question 1
Does the state subtract the criminal background check from the individual budget? If so, does the state account for the criminal background check in each individual's needs assessment and then add money for it to the individual budget?

Answer:
No, the state will not subtract the criminal background check from the individual's budget. The state accounts for the criminal background check as part of the individual budget as an administrative function of the fiscal agent.

Question 2
Examples from question 6 regarding employment related training should go in the Appendix B definition of employment related training. Also, change the name of facility based employment to employment related training in the definition in Appendix B.

Answer:
Examples added and wording change made.

Question 3
Will the entire waiver be phased in regionally, or only the self-directed part of it? What happens if an individual in a region that does not have self-direction during the phase-in process wants self-direction?

Answer:
This waiver has been developed on the principals of self-determination. Only the consumer directed payment option will be phased in regionally. Therefore, should an individual in a region that does not have the consumer direction payment option want self-direction he/she will be able to access all other aspects of self-direction such as recommend hiring and firing support staff and development of an individual budget; just not the availability of the payment option until the phase in reaches his region. As explained earlier, Louisiana would rather phase the consumer direction payment option in, to build system capacity and insure that the process is effective and allows adequate safeguards for the participant, employees of the participant, the state of Louisiana, and CMS.

Question 4
In appendix G-1, please make factor D consistent with Appendix G-8.

Answer:
This has been corrected.

Question 5
Identify estimated administrative costs for the Financial Management Services and the method used to calculate them (did you compare rates for other states or an existing system, use historical information, or use claims, etc).

Answer:
The administrative costs that have been identified and are outlined in the Request for Proposal (RFP) for the fiscal agent as follows: Initial contact and enrollment fee, cannot exceed $50, orientation and training fee cannot exceed $100, the monthly management and related costs fee cannot exceed $75.

Additionally, the RFP requires the contractors to propose their own fee schedule worksheet based on the above criteria and include this as a part of the RFP response. Therefore the costs of these services may be less than outlined above.

These rate ranges were based on a review of national data by the stakeholder task force that developed the framework for the consumer direction payment option.

Immediate Jeopardy	Substandard Compliance	Substandard Compliance with Repeat Deficiencies	Satisfactory Compliance with Recommendations For QA/QI Plan	Satisfactory Compliance
1. Immediate Jeopardy Guidelines followed to assure safety and welfare of the recipient.	1. Statement of Deficient Practice issued and a request for a Corrective Action Plan sent w/in 14 Calendar days	1. Repeat deficiencies are identified, citation of repeat deficiencies and a request for a Corrective Action Plan	1. No Citation of Deficient Practice	1. No Citation of Deficient Practice
2. Citation of Deficient Practice and a request for a Corrective Action Plan	2. Corrective Action Plan approved or denied.	**2. Corrective Action Plan approved or denied.**	2. BCSS recommends that all concerns identified during the site visit be addressed through the agency QA/QI Program	
3. The provider has 30 days from the approval of the plan to implement their plan and correct the deficient practices	3. The provider has 30 days from the approval of the plan to implement their plan and correct the deficient practices	3. The provider has 30 days from the approval of the plan to implement their plan and correct the deficient practices	3. BCSS reviews the QA/QI Plan upon the next site visit	
4. A follow-up visit by BCSS R/O w/in 90 days to validate the correction and clear the deficiencies.	4. A follow-up visit by BCSS R/O w/in 90 days to validate the correction and clear the deficiencies.	4. A follow-up visit by BCSS R/O w/in 90 days to validate the correction and clear the deficiencies.	4. The provider's annual self-evaluation should include the actions taken related to the concerns noted during BCSS site visit.	
5. Monetary or administrative sanctions are imposed.	5. If the agency fails to correct the deficiencies within the time frame, monetary or administrative sanctions may be imposed.	5. If the agency fails to correct the deficiencies within the time frame, monetary or administrative sanctions will be imposed.		

Sanctions include:

1. Immediate Jeopardy situation is identified and Guidelines are followed.

BCSS Administration, in collaboration with the BCSS Regional Office,

STATE: Louisiana Date: April 1, 2003

makes a determination regarding imposition of sanctions based on the circumstance of the Immediate Jeopardy Situation and the Medicaid Providers actions in response.

Possible sanctions include:

Administrative Warning
Suspension of linkages for a period of time
Withholding Medicaid Payment
Recover of Monies
Referral to SURS/AG's Office
Termination of Contract
Liquidated Damage

2. Site visit reveals Substandard Compliance involving Waiver Assurances and/or repeat deficiencies:

   1st time Suspension of new linkages and imposition of monetary sanctions up to $300 per day until corrective action is documented.

   2nd time Withholding of Medicare payment and dis-enrollment begins after 30 days

3. Site visit reveals Substandard Compliance with Repeat Deficiencies:

   1st time Repeat deficiencies or failure to correct cited deficiencies: Liquidated damages assessed

   2nd time Repeat deficiencies or failure to correct cited deficiencies: Withholding Medicaid payment and loss of enrollment as a waiver provider.

DEFINITIONS:

Immediate Jeopardy:

A situation in which the provider's non-compliance with one or more standards of care and/or provider regulations has caused or is likely to cause, serious injury, harm, impairment, or death to the recipient.

Abuse:

The infliction of physical or mental injury on a recipient by other parties, including, but not limited to such means as sexual abuse, exploitation, or extortion of funds, or other things to such an extent that the individual's health, self-determination, or emotional well being is endangered.

Neglect:

The failure, by a care giver responsible for an individual's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his /her well-being.

Sexual Abuse:

Abuse includes any non-consensual sexual activity between a recipient and another person; or any sexual activity between a recipient and another recipient or any other person in which the recipient is not competent to give consent. Sexual activity includes, but is not limited to kissing, hugging, stoking, or fondling with sexual intent; oral sex or sexual intercourse; insertion of objects with sexual intent, request, suggestion, or encouragement by another person for the recipient to perform sex with any person when the recipient is not competent to refuse.

Exploitation:

The illegal or improper use or management of the aged or disabled individual's funds, assets or property, or the use of the the individual's power of attorney or guardian for one's own profit or advantage.

Extortion:
The acquisition of a thing or value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority.

Voluntary ClosureWithdrawal (opting out) from the Consumer Direction Service Initiative:

The selection of the Consumer Directed Service Option is strictly voluntary and the person with disabilities may choose at any time to withdraw from the initiative and return to traditional waiver services. This action would constitute a change in the services needs of the individual and would necessitate an Interdisciplinary Team Meeting for re-planning and development of a new CPOC.

Involuntary Withdrawal from the Consumer Direction Service Initiative

Involuntary withdrawal may occur for the following reasons:

1. At any time BCSS determines that the health, safety and welfare of the participant is compromised by continued participation in the Consumer Direction Initiative, the participant may be required to return to traditional home and community-based waiver services.

2. Should the participant's ability to direct his/her own care to a point they can no longer do so and there is no responsible representative to direct the care, the participant will be required to return to traditional
home and community based waiver services.

3. Should the participant or the authorized representative consistently fail to pay or place barriers to the payment the salaries of direct care staff and related state and federal payroll taxes, the participant may be required to return to traditional home and community-based waiver services.

4. Should the participant/authorized representative consistently fail to follow the Individual Budget as planned in accordance with their Comprehensive Plan of Care, the participant may be required to return to traditional home and community-based waiver services.

5. Should the participant/authorized representative consistently fail to provide required documentation of expenditures and related items or fail to cooperate with the Fiscal Agent in preparing the documentation of expenditures, the participant may be required to return to traditional home and community-based waiver services.

6. Should the participant become ineligible for Medicaid and/or Home and Community-based Waiver, the applicable rule for case closure/discharge will be applied.

Due Process procedures will be followed in the event that problems persist and a successful

resolution could not be reached through the person centered planning process. Procedures include:

1. A written notice, explaining the reason for the action and citing the policy reference, is provided the participant/authorized representative.

2. An effective opportunity to defend through an informal appeal to BCSS regional office will be provided.

3. The opportunity to present arguments and evidence orally and with counsel before an impartial Administrative Law Judge will be offered.

4. DHH Fair Hearing Policies and Procedures will be followed for all appeals.